

IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR THE COUNTY OF MULTNOMAH

The Estate of JESSE D. WILLIAMS,)
Deceased, by and through)
MAYOLA WILLIAMS, Personal)
Representative,) Vol. 12-A
Plaintiff,) Circuit Court
vs.) No. 9705-03957
PHILIP MORRIS INCORPORATED,)
Defendant.)

TRANSCRIPT OF PROCEEDINGS

BE IT REMEMBERED, That the above-entitled
matter came on regularly for Jury Trial and was
heard before the Honorable Anna J. Brown, Judge of
Department No. 7C, of the Circuit Court of the
County of Multnomah, State of Oregon, commencing at
9:00 a.m., Tuesday, March 9, 1999.

* * *

Reported by Jennifer L. Wiles, CSR, RPR.

1 APPEARANCES:

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James Coon, Attorney at Law,
William Gaylord, Attorney at Law,
4 Ray Thomas, Attorney at Law,
Christopher Tauman, Attorney at Law,
5 appearing on behalf of the Plaintiff;

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James Dumas, Attorney at Law,
Michael Harting, Attorney at Law,
8 Billy Randles, Attorney at Law,
Walter Cofer, Attorney at Law,
9 Jay Beattie, Attorney at Law,
appearing on behalf of the Defendant.

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* * *

1 (March 9, 1999)

2 * * *

3 A.M.P R O C E E D I N G S

4 * * *

5 THE COURT: We have got about ten minutes
6 if there are things we could do before the jury
7 comes in, but whenever you are ready we can do
8 something.

9 And you wanted to say?

10 MR. COON: I did have something for the
11 record.

12 THE COURT: All right. Let's go on the
13 record then. May we do that?

14 Go ahead.

15 MR. THOMAS: I was looking my notes over
16 from the opening statements and realized and read
17 that Mr. Cofer had told the jury that there had
18 been 11 members of the Williams family who had
19 quit smoking cigarettes.

20 And I would like to move that the Court
21 exclude evidence about other family members who
22 have quit as being irrelevant.

23 And to the extent that it is relevant
24 it's also a 403 issue because, of course, it's an
25 invitation to some response, and the response is

1 well, how many family members were unable to
2 quit? Who quit? Who didn't? How did they quit?
3 What they smoked?

4 I mean, it's just, Jesse Williams, as you
5 know from the photograph, had I think six
6 brothers and sisters and six kids, and Mayola
7 Williams has a large extended family. I mean,
8 there are lots of people involved in these
9 families. And also there is I think 12
10 grandchildren.

11 So, the question of who was able to quit
12 doesn't really have anything to do with the
13 question of Jesse Williams, particularly in light
14 of the fact that this Plaintiff has not claimed
15 that Jesse Williams is taking no responsibility
16 whatsoever, nor is the Plaintiff claiming that
17 Jesse Williams was so hopelessly addicted that he
18 had completely totally lost control over any free
19 will that he had.

20 Under those circumstances, the question
21 of who quit and who didn't has no real bearing on
22 any issues in the case.

23 THE COURT: Mr. Randles.

24 MR. RANGLES: I can take that one, Your
25 Honor. It's relevant for two reasons that have

1 some sub reasons.

2 The first reason goes to notice of the
3 risks of smoking. If large numbers of a person's
4 family are quitting smoking, it is fair to point
5 that out and to point out the reasons that they
6 are quitting smoking and, therefore, the
7 conversations that go on in the family about the
8 health risks of smoking. That is the first one.
9 Well, it's not dispositive. It is useful
10 evidence on that point.

11 The second point is the point of genetic
12 susceptibility or the lack thereof. Plaintiff's
13 counsel introduced evidence in the case, this
14 case, through Dr. Benowitz that African Americans
15 may have a more difficult time quitting smoking,
16 that the way they smoked may be different, that
17 the way nicotine affects them may be different.

18 Defendants, on the other hand, responded
19 to that with 50 million Americans have quit
20 smoking; the overwhelming majority with no
21 assistance.

22 Our position is that there's no evidence
23 in this case that Mr. Williams is different or
24 unique from the 50 million Americana that have
25 quit smoking, but more specifically he is not

1 unique from the members of his family.

2 Now, I realize Dr. Benowitz said well,
3 the only identical genetic markers are identical
4 twins, but we all know, and the jury is certainly
5 free to infer, when we are talking about genetic
6 susceptibility, looking at a person's blood
7 relatives is certainly a reasonable way to go
8 about that. So, it goes to ability to quit.

9 Now, Plaintiff's counsel said something
10 interest this morning that I wasn't sure I
11 understood. And that is, well, we accept some
12 undefined amount of responsibility, and we don't
13 say Mr. Williams was totally unable to quit.

14 But apparently they are saying somehow it
15 was so difficult for him his responsibility
16 should be diminished. That continuum of
17 addiction that I suppose they are talking about
18 is an important issue in this case. And it's
19 certainly relevant for the jury to look at other
20 people similarly situated, with similar factual
21 information available to them, and with a similar
22 genetic background, to see whether that argument
23 holds water. We won't argue that is dispositive,
24 but we think it's relevant.

25 THE COURT: And on his 403 point?

1 MR. RANGLES: I don't think there is
2 anything particularly confusing or unfairly
3 prejudicial about it. They are saying that
4 Mr. Williams was somehow uniquely impaired in his
5 ability to stop smoking and that is apart from
6 the genetic issues and race issues raised by
7 Dr. Benowitz. And I believe the race issues were
8 repeated by another witness, but I don't recall
9 which one at the moment.

10 And also Dr. Pollay referenced racial
11 targeting of advertisements as perhaps some
12 diminishment in a person's ability to quit.

13 So, I don't think it's confusing at all.
14 It's offered for a very precise point, and it's
15 certainly not unfairly prejudicial because it
16 goes to one of the core issues in the case.

17 I don't see how it creates some negative
18 impression in the minds of the jury of
19 Mr. Williams or his family.

20 THE COURT: Anything else?

21 MR. THOMAS: Yes, ma'am.

22 THE COURT: Mr. Thomas.

23 MR. THOMAS: First of all, the question
24 of what family members told him about the dangers
25 of smoking is not something that we're seeking to

1 limit in terms of them being able to put on proof
2 of what Jesse Williams knew. In fact, the
3 depositions went into great detail about that.

4 Secondly, one thing that is in the
5 background here that I think in terms of the 403
6 analysis the Court needs to know about or have
7 raised is that in the background here is the
8 Jehovah's Witness faith. And the Court knows
9 that a prohibition exists in that faith in regard
10 to smoking and that there are a number of family
11 members who are and a number who are not involved
12 in that faith.

13 It's going to be very difficult if we get
14 into individual smoking histories not to bring in
15 the fact that the Jehovah's Witness prohibition
16 has much to do with these family members'
17 personal decisions.

18 THE COURT: Anything else?

19 MR. RANGLES: Just we agree the Jehovah's
20 Witness material should not be gone into. And I
21 believe that questioning can be crafted around
22 those issues to not call for that.

23 THE COURT: The first point to note is
24 that you have had eight days of testimony. We
25 are not at the beginning of the trial. I believe

1 this issue was raised in motions in limine. And
2 the arguments were similar to what I have just
3 heard, that there was a legitimate purpose for
4 which that evidence was being proffered, namely
5 awareness on the part of the decedent, through
6 observing and discussion with familiar members
7 their decisions to attempt and in some cases
8 apparently successfully quitting smoking.

9 We didn't discuss at the motion in limine
10 stage the genetic susceptibility issue. And I'm
11 a little concerned about labeling lay witness
12 testimony with that scientific inference.

13 But it is true that Plaintiffs have
14 introduced evidence that Mr. Williams was
15 addicted, that African American males may have a
16 more difficult time than the generic 50 million
17 Americans quitting tobacco use.

18 And having introduced that, I think there
19 is some more legitimacy to introducing just
20 anecdotal evidence, not scientific evidence, but
21 anecdotal evidence that African Americans in
22 Mr. Williams family who were smokers chose to
23 quit or succeeded in quitting.

24 Each presentation of evidence by the
25 Plaintiffs carries some of those risks in terms

1 of what can be presented in defense.

2 And when the argument ultimately reduces
3 to one of unfair prejudice, I have to assume that
4 Plaintiffs considered those kinds of risks going
5 in, since we had the issue come up in motions in
6 limine.

7 I am not prepared this far down the road
8 to change course on the admissibility of evidence
9 that family members succeeded in quitting.

10 However, there may be some need to review
11 the issue depending upon how that evidence gets
12 presented by Plaintiff and the defense.

13 I don't think allowing evidence that a
14 particular family member has quit or that 11
15 family members quit makes admissible reasons why
16 they quit, except to the extent those reasons
17 bear on the family member communicating to
18 Mr. Williams that there were health issues
19 concerned.

20 Because if we go into the whys and
21 wherefores of another individual's decision to
22 quit, inevitably we are going to have to get into
23 the whys and wherefores of other family members
24 who tried and didn't succeed.

25 That carries with it a risk of diversion

1 and time consumption that can't be justified, and
2 it carries with it the obvious risks that we'll
3 get into the religious issues which both sides
4 have wanted to avoid.

5 So, to the extent Defendant's offer the
6 evidence to show notice to the decedent about the
7 health risks of smoking, the evidence needs to be
8 framed in that light.

9 And while it may be something that can be
10 argued at the end of the case in response to
11 Plaintiff's arguing this African American male
12 was different than the 50 million Americans who
13 were able to quit smoking, it may be arguable at
14 the end of the case. No, he wasn't. People in
15 his own family quit. And then the rebuttal to
16 that is well, if you want to argue genetics, the
17 only evidence that we have so far is that you
18 have to have an identical genetic makeup for that
19 kind of inference to be drawn.

20 But, so far, I don't see any basis for
21 the Defendant to offer evidence of other family
22 members quitting for the purpose of showing some
23 genetic ability to quit in the Williams family.
24 There just isn't a foundation for that. And that
25 purpose so far isn't appropriate.

1 MR. RANGLES: May I respond, Your Honor,
2 just briefly?

3 Actually the evidence would be offered
4 for the converse, and we'll have experts prepared
5 to talk about it, that the fact that this science
6 that there's a genetic susceptibility to
7 addiction or racial component to the inability to
8 quit is not well-founded.

9 And one of the ways to look at that
10 evidence and one of the ways to apply it to a
11 particular case is to look at the closest genetic
12 folks to a person, and that --

13 THE COURT: Stop there. If you're
14 telling me that it is not well-founded to
15 conclude that there is a genetic disposition to
16 nicotine, the addiction, then the opposite
17 inference from what I understood you would be
18 offering the family evidence for is really
19 appropriate, which is to say if there's no
20 genetic connection the fact that family members
21 quit is not probative of the fact that
22 Mr. Williams could have quit.

23 MR. RANGLES: I don't think I'm being
24 very clear. Can I try one more time? And I
25 apologize.

1 THE COURT: Quickly.

2 MR. RANGLES: I'm not saying the
3 testimony will not be offered to say because his
4 relatives quit he could quit. The testimony we
5 offer to say as part of the picture is that it's
6 speculation; that there's a genetic inability to
7 quit is absolutely not founded in either science
8 or experiments. To talk about the weakness in
9 science and then point out in this case the only
10 evidence we have of genetics goes the other way.

11 THE COURT: I didn't hear Plaintiff say
12 there was a genetic inability to quit. I'm
13 getting body language from counsel suggesting
14 that that is accurate.

15 MR. THOMAS: That's correct.

16 THE COURT: Nobody is contending there is
17 a genetic inability to quit. You are the one who
18 said genetic susceptibility this morning. And I
19 was trying to understand the genetic
20 susceptibility purpose for which the family
21 quilting evidence might be probative. And you
22 have just said you are not taking the position
23 that because family members quit he necessarily
24 could have had the genetic makeup to quit.

25 MR. RANGLES: Right.

1 THE COURT: Which takes me back to where
2 I was, which is to say that is not a proper
3 purpose for family quitting evidence.

4 There is a proper purpose for family
5 quitting evidence in terms of its notice to the
6 Defendants. So the evidence has to be framed in
7 terms of that Mr. Williams was aware of it
8 happening or it had been discussed with him, and
9 for that purpose only.

10 MR. THOMAS: Would a limiting instruction
11 be appropriate?

12 THE COURT: I don't know. Ask for one
13 when it comes in, and tell me that you want it,
14 and I'll make the decision then. A lot depends
15 on the form of the question.

16 MR. THOMAS: Would it be less, if we had
17 a limiting instruction at that point, that we
18 could submit it to the Court at the appropriate
19 time?

20 THE COURT: Well, if questioning comes in
21 the context of you quit, you told Jesse or your
22 grandfather Jesse, or your brother Jesse that you
23 quit, and you explained to him that you quit
24 because you were concerned about the health risks
25 of smoking, and if you want a limiting

1 instruction, I will say to the jury then:
2 Evidence that members of Mr. Williams' family may
3 have quit smoking may be considered by you for
4 its bearing, if any, on whether Mr. Williams was
5 aware of health risks of smoking.
6 That is point.
7 MR. THOMAS: All right.
8 THE COURT: So, he doesn't need to write
9 one really.
10 MR. THOMAS: I think she's got it.
11 MR. DUMAS: He wants to write one, Your
12 Honor.
13 THE COURT: Mr. Coon doesn't have enough
14 to do.
15 All right. Is there anything else that
16 we can quickly handle before we bring in the
17 jury? All right. I take it we are doing a
18 reading?
19 MR. THOMAS: Yes.
20 THE COURT: And then what?
21 MR. GAYLORD: We have a witness at 10:30.
22 THE COURT: Okay.
23 Do we have all 16?
24 THE CLERK: Yes.
25 THE COURT: Bring them in, please.

1 Mr. Dumas, two orders were handed to me
2 yesterday on the Dr. Farone 104 hearing. And I
3 understand the only difference is that one of
4 them says -- one of them has a broader statement
5 about what Dr. Farone may testify to.

6 I'm a little worried about all of these
7 written orders on rulings I have made during the
8 trial that are now over and done with because
9 Farone has testified and the time that it's
10 taking us to do that.

11 But both of them are accurate. I mean, I
12 made both of those statements. So is there a
13 real problem with this?

14 MR. DUMAS: There's not.

15 THE COURT: The jurors are coming in.

16 Is there a problem? Yes or no.

17 MR. DUMAS: Either one is fine, Your
18 Honor. It would take me 30 seconds to discuss
19 it.

20 THE COURT: But does it matter to you?

21 MR. DUMAS: It was a written motion. We
22 would prefer a written order.

23 THE COURT: Does it matter to you?

24 MR. COON: We don't need the order at
25 all. We believe the longer one is the accurate

1 one.

2 THE COURT: He doesn't object to the
3 longer one. So, I'm signing that one.

4 MR. COON: Thank you.

5 MR. DUMAS: Thank you.

6 THE COURT: I said both of those things,
7 but, you no, I just question the utility of
8 written rulings during this trial. You have got
9 a transcript, and we have got to conserve, all of
10 us, all of our resources.

11 * * *

12 (Whereupon, the following proceedings took
13 place, in open court, in the presence of the
14 jury, as follows:)

15 * * *

16 THE COURT: And good morning, jurors.

17 THE JURORS: Good morning.

18 THE COURT: We are ready to continue with
19 the Plaintiff's case.

20 Mr. Thomas.

21 MR. THOMAS: Your Honor, Plaintiff is
22 going to call to the stand a fellow by the name
23 of William Raymond Morgan, who was deposed, and
24 the deposition was April 24th, 1997, and the
25 person who will be doing the reading of the

1 witness is Doug Swanson.

2 THE COURT: All right.

3 Mr. Swanson, would you take the witness
4 chair, please?

5 Jurors, just so there's no confusion,
6 when a witness is deposed the witness is giving
7 testimony under oath. That testimony, that
8 witness testimony is being read to you. The
9 witness testimony is being read to you because
10 the witness cannot be here live.

11 Go ahead, Mr. Thomas.

12

13 DR. WILLIAM RAYMOND MORGAN

14 was thereupon called as a witness on behalf of the
15 Plaintiff and, having been previously duly sworn,
16 the proceedings were read into the record by
17 Plaintiff's counsel and the answers were read by
18 Mr. Doug Swanson, as follows:

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DIRECT EXAMINATION

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BY MR. THOMAS:

Q. Would you state your name for the record please?

A. It's William Raymond Morgan.

Q. Can you briefly describe for us your educational background, sir?

A. I have a Bachelor of Science Degree in chemistry from North Georgia College and a Ph.D. in chemistry from the University of Georgia.

Q. Are you familiar with the research concerning whether nitrosamines are carcinogenic compounds?

MR. RANGLES: Excuse me, counsel. Where are you?

MR. THOMAS: 23-21.

MR. RANGLES: I think you skipped something.

MR. THOMAS: Okay. Sorry.

BY MR. THOMAS:

Q. Can you briefly describe for us your work experience, including military experience from the time you completed your education in 1992?

A. I received my Ph.D. in 1970. I was on

1 delayed entry on active duty in the Army, because I
2 went to a military school, North Georgia College
3 was a military school, and I was commissioned in
4 the Army in 1965. When I graduated there, I had a
5 delay on entry to active duty.

6 So, upon completion of my doctoral work,
7 I entered the Army and served from 1970 to '72, and
8 I was stationed in Charlottesville, Virginia, as a
9 member of the United States Army's Foreign Science
10 and Technology Center, and we were responsible for
11 scientific and technical intelligence work.

12 Upon my completion of my military
13 service, which was in March of 1972, I had obtained
14 a position with Philip Morris, and at the end of
15 March began working at Philip Morris as an
16 analytical chemist in the Analytical Research
17 Division. I worked in that division until 1984,
18 and in February of '84 I transferred to the
19 Biochemical Research Division, and I was in that
20 division until I was released from Philip Morris in
21 1992.

22 Q. Why did you transfer over to the
23 Biochemical Research Division?

24 A. I requested it.

25 Q. And why did you make that request?

1 A. Work that I was doing with, in Analytical
2 Research Division with trace metal analysis, in
3 putting together my plans for the research that I
4 wanted to do for 1984, management had decided that
5 they did not want to pursue that area of research.
6 They suggested that it might be more appropriate
7 for that research to be done in the Biochemical
8 Research Division.

9 I contacted the manager of Biochemical
10 Research and met with him. That was Jim Charles at
11 the time. He was not interested in pursuing that
12 research, but suggested that he had an opening in
13 the nitrosamine group, if I would be interested in
14 that. And I said I would be interested, and the
15 transfer took. It occurred shortly thereafter.

16 Q. That was in 1984. Do you remember the
17 month?

18 A. February.

19 Q. And in February 1984, did you pretty much
20 immediately go over to the nitrosamine group?

21 A. Yes.

22 Q. What was the nitrosamine group?

23 A. It was a group within the Biochemical
24 Research Division that were setting nitrosamines.

25 Q. And who were members of that group?

1 A. The project leader at that time was a Sue
2 Tafur, T-a-f-u-r, and Jim Charles was the manager
3 and there were approximately seven or eight other
4 members that were chemists within the group,
5 chemists or technicians within the group.

6 Q. What is a nitrosamine?

7 A. It's a secondary amine that has a NO
8 group attached to the nitrogen in the amine.

9 Q. And what you say NO group attached to the
10 nitrogen in the amine, what are you referring to?

11 A. As --

12 Q. What does the NO group mean?

13 A. It's a nitrogen oxide group. It's
14 bonded, where there is a nitrogen, nitrogen bonded
15 within the amine and the NO group.

16 Q. And do you know how these nitrosamines
17 are formed in cigarette or tobacco smoke?

18 A. The chemistry of how they are formed or
19 they -- they are formed in two ways, in the growing
20 of tobacco. Nitrosamines are formed during either
21 the growing and the curing process, and these are
22 referred to as -- we refer to them as endogenous
23 nitrosamines. And those were, what we refer to as
24 tobacco-specific nitrosamines, because they're
25 alkaloid. Their origin for the organic group were

1 the alkaloids that were in the tobacco.

2 During the smoking of tobacco, there are
3 additional nitrosamines of the same type, three,
4 there are really three major ones referred to as
5 NNN, NAF, and NNK. There are those three.

6 There's additional quantities that are
7 formed during the actual combustion of the
8 cigarette, and we refer to those as
9 pyrosynthetically formed.

10 Q. Pyrosynthetically formed?

11 A. Right, because they were formed during
12 combustion of the cigarette.

13 Q. Are you familiar with the research
14 concerning whether nitrosamines are carcinogenic
15 compounds?

16 A. I'm familiar with what's in the
17 literature.

18 Q. And what does the literature say?

19 A. The literature says that as in studies on
20 mice, laboratory animals, that there are very
21 potent carcinogens, in particular, NNN and NNK.

22 Q. Now, NNN and NNK and NAT, all are formed
23 during the smoking of tobacco; is that correct?

24 A. They are formed during the growing of
25 tobacco, during either the growing process and

1 curing process, and they are also formed during the
2 burning of the cigarette, during the combustion of
3 the cigarette.

4 Q. Is one more or less volatile than the
5 other or do you know?

6 A. NNK is a little more volatile than the
7 others, to the best of my recollection. I did some
8 studies on decomposition temperatures for the
9 various nitrosamines and, to the best of my
10 recollection, NNK had the lowest decomposition
11 temperature, which would indicate that it was
12 potentially a little more volatile.

13 Q. Now, when this research was conducted,
14 did you use actual cigarette to do the research?

15 A. We used reference cigarettes.

16 Q. What is a reference cigarette?

17 A. There are generally two kinds. There was
18 one that was referred to as a Kentucky reference
19 cigarette, which was available to all tobacco
20 companies to be used throughout the industry.

21 And then we had a group at Philip Morris
22 referred to as Semi-Works, which was a facility
23 that they could make cigarettes to order,
24 so-to-speak, and we could request to have
25 cigarettes made in just about any configuration

1 that we want them. And we would have, if we wanted
2 to, say, do measurements on a cigarette that was
3 like a Marlboro, we would have them make a
4 cigarette that was like a Marlboro, but it wasn't
5 actually a Marlboro because it wouldn't have the
6 flavors added to it or what have you. But it would
7 have the same paper, essentially, the same blend,
8 the same filter, what have you, and we would refer
9 to that as a reference cigarette.

10 Q. When you say the additives, the
11 flavorings weren't added into it, how do you know
12 that?

13 A. Because we requested they not be added.

14 Q. What was the reason for requesting that
15 the flavorings and the additives not be added?

16 A. Because if they were going to do that we
17 would just get production cigarettes off of the
18 line, and we were told not to do nitrosamine
19 studies on production cigarettes.

20 Q. Who told you not to do nitrosamine
21 studies from production cigarettes?

22 A. Management.

23 Q. Do you have specific names that you can
24 recollect?

25 A. No.

1 Q. Was it more than one person who
2 management who said this?

3 A. It was. When I came on board with the
4 nitrosamine project, it was told us to at that
5 point it was already, I guess, a standing order for
6 the people that were already not working on the
7 project, and then it was just passed on to me that
8 when we did studies we did them on reference
9 cigarettes and not on a production cigarette.

10 Q. How long had the nitrosamine research
11 group been in existence prior to the time that you
12 were there, if you know?

13 A. I don't know exactly. It started, I
14 know, probably at least a couple of years prior to
15 my joining.

16 Q. And did you begin doing research on
17 nitrosamines immediately upon starting over there
18 in February of 1984?

19 A. Yes, I did.

20 Q. And the instruction that you were given
21 not to use production cigarettes, that was made
22 clear to you immediately upon beginning that job?

23 A. The first part of the work that I did was
24 actually learning the procedures that were in place
25 for the collection and the analysis. And in that

1 case we were just using reference cigarettes. But
2 then it was time for me to start actually designing
3 experiments to study, it was, I was told that we
4 would not use production cigarettes, but would use
5 reference cigarettes.

6 Q. Did you ask why?

7 A. No.

8 Q. Did you know why?

9 A. I think I had a pretty good idea why.

10 Q. Do you have an opinion as to why you were
11 told not to use production cigarettes? Do you have
12 an opinion?

13 A. I have an opinion.

14 Q. What is it?

15 A. That they don't want to know.

16 Q. And what's the basis for that opinion?

17 A. My basis for that opinion?

18 Q. Yes.

19 A. My basis for that opinion would be that
20 we would not -- so that they would not have a
21 record on production products for nitrosamines. If
22 there was any litigation, that they, then they
23 wouldn't have to -- they would not have that
24 information.

25 Q. The research that was done on

1 non-production cigarettes, was that -- well, how
2 that was done? What was -- by that, I mean I
3 should explain further.

4 What was the procedure for putting
5 together all of the research and for keeping track
6 of the research or keeping notation on the
7 research?

8 A. As far as notations on the research, any
9 work we did it was recorded in our laboratory
10 notebook. As far as the cigarettes themselves and
11 the design of experiments, a lot of the experiments
12 we did, we did not have production cigarettes that
13 matched parameters we needed to measure. If we
14 wanted to, say, study construction parameters, we
15 would make cigarettes with varying types of filters
16 or varying types of paper or varying circumferences
17 or various types of filler. Say it may be a single
18 type like a burly relative to blend. So, those
19 types of cigarettes were not production cigarettes
20 so we had to have them made separate.

21 Q. So, was that kind of research done for
22 purpose -- well, let me put it another way. What
23 was the purpose of that type of research, if you
24 know?

25 A. To have understand the basis of the

1 origin of nitrosamines, to see how burly, different
2 from bright, different from oriental, say, to see
3 how if the combustion parameters, if there was a
4 change in say the relationship to the circumference
5 of the cigarette with the packing density of the
6 filler, the type of paper that was on it, if it had
7 an impact on it. There were a lot of parameters
8 that -- and you had the cigarettes that were made
9 to address the particular parameter that you were
10 looking for.

11 Q. Aside from measuring those types of
12 parameters for that purpose, were there any other
13 purposes for doing the research that the
14 nitrosamine research group did?

15 A. We monitored the literature and if
16 information was reported say with reference to a
17 different analysis procedure or whatever, we would
18 duplicate that procedure to see if it gave the same
19 results that -- prosecutor we were using for
20 analysis. We also were studying, trying to get a
21 better knowledge of, especially with the
22 pyrosynthetically-produced nitrosamines, how they
23 were produced and were there ways to prevent that
24 formation.

25 We also looked at the correlation for the

1 formation of the endogenous nitrosamines as to what
2 parameters might contribute to their formation and
3 also ways that we might treat or process the
4 tobacco to lower those levels.

5 Q. During the course of the research, did
6 the group or anyone in the group measure the
7 nitrosamine level, just measure the amount of
8 nitrosamine in a given cigarette, whether it be
9 non-production or production?

10 A. Could you repeat that? Did we?

11 Q. Did anyone in the group, in your group,
12 measure the nitrosamine level in either a
13 non-production cigarette or a production cigarette?

14 A. We did it all of the time.

15 Q. Well, why did you do that?

16 A. Why do we measure the level of
17 nitrosamine? That was the object. I mean, the
18 objective of the project was to study the levels of
19 nitrosamines.

20 Q. When you studied the levels of
21 nitrosamines, in follow a non-production cigarette,
22 that was like a Marlboro, from a scientific
23 standpoint, was that the best way to study
24 nitrosamine level of a Marlboro itself?

25 A. No. It was, would be a way of studying

1 levels in, that existed in smoke, either mainstream
2 or sidestream for that particular construction
3 parameter, being a blend that was similar to
4 Marlboro, type of paper, type of filter, et cetera.
5 We would also have a reference cigarette or one
6 made in Semi-Works that would be similar to say a
7 Virginia Slims or maybe one that was similar to a
8 Cambridge that had a very high filtration or
9 different type of dilution in the paper. It was
10 just --

11 Q. When you, for example, would do a
12 cigarette, look at a cigarette that was like a
13 Marlboro, did you actually get nitrosamine level
14 readings on cigarettes that were supposed to be
15 like Marlboros but not actually Marlboros?

16 A. I don't know because we didn't run
17 Marlboros. I don't know what those were.

18 Q. Well, let me rephrase. Did you ever test
19 a cigarette that was considered to be like a
20 Marlboro?

21 A. We studied cigarettes that had
22 essentially the same blends, paper, filter, deliver
23 the same TPM level, nicotine, has close to a
24 Marlboro as possible, and the only difference
25 essentially would be that it didn't have the flavor

1 components added.

2 Q. And what was your understanding of the
3 purpose of measuring the nitrosamine level in a
4 cigarette that was like a Marlboro?

5 A. It was just one of the many ways of
6 configurations that we studied.

7 Q. Would it -- go ahead.

8 A. When I say like a Marlboro, Marlboro is
9 the best selling cigarettes in the world, and so,
10 and other cigarettes that R.J. Reynolds makes and
11 other companies all had similar cigarettes that
12 were similar to a Marlboro as far as delivery of
13 tar and nicotine. And I would guess that if you
14 take those cigarettes from all of the companies and
15 put them together, they constitute a majority of
16 all of the cigarettes that are sold. And so
17 studying a cigarette that was similar in
18 configuration to that cigarette would be something
19 that would be most like what your -- what you would
20 generally encounter in the world.

21 Q. When did you first begin doing or
22 participating in the research that would do
23 nitrosamine level measurements of cigarettes like
24 Marlboro or like Cambridge or like Virginia Slims
25 or like any of the other brands?

1 A. Almost immediately upon joining the
2 nitrosamine group.

3 Q. And?

4 A. See, you had a Kentucky reference
5 cigarette that was a filtered cigarette that was
6 essentially like a Marlboro.

7 Q. What was missing from it?

8 A. It might have a slightly different paper.
9 It might have -- wouldn't have any flavored
10 additives, but it would produce essentially the
11 same filtration efficiency and the same TPM and
12 nicotine delivery as the Marlboro or Winston, and
13 it would be in that ballpark.

14 And these cigarettes we used, especially
15 the Kentucky reference cigarettes, we used
16 industry-wide, and they were used by I guess just
17 about every research project within Philip Morris,
18 and I presume other companies for studying a whole
19 host of different types of studies that were going
20 on.

21 Q. Did you ever have occasion to actually
22 test a production cigarette?

23 A. Yes.

24 Q. And how much higher was the nitrosamine
25 level in the Virginia Slims cigarette?

1 A. It was approximately ten times higher
2 than we had measured with non-reference cigarettes.

3 Q. So, when you saw this level of 12,000
4 nanograms, what, if anything, did you do?

5 Page 38.

6 A. Can you repeat the question?

7 Q. Yeah.

8 So, when you saw this level of 12,000
9 nanograms, what, if anything, did you do?

10 A. I was very surprised to see it, and I
11 compiled the data from the, that I had recorded off
12 of the integrators on our detectors, and I took the
13 data and showed it to my section leader Robin
14 Kinser.

15 Q. And what, if anything, did Robin Kisner
16 do?

17 A. She asked me what cigarette it was.

18 Q. And what did you tell her?

19 A. I told I her I did not know. I only had
20 a code, a run code from the chamber.

21 Q. And did you provide her with a code, the
22 run code?

23 A. It was written on the notes, yes.

24 Q. And after you told her that, what if
25 anything did you do?

1 A. She --
2 Q. Who is she?
3 A. Robin. Robin called Roger Comes, who was
4 in charge of the chamber, and inquired as to what
5 cigarette that was for, that run, and I was sitting
6 there and after she finished talking to him she
7 told me it was a Virginia Slims.
8 Q. Robin -- who told you it was a Virginia
9 Slims?
10 A. Robin Kisner.
11 Q. And who is Robin?
12 A. She was a section leader.
13 Q. Shivers supervisor?
14 A. One of them, yes. I had a project
15 leader, and then there was a section leader, which
16 she was, which was kind of like an assistant
17 manager.
18 Q. And she was a manager for Philip Morris?
19 A. Like an assistant manager.
20 Q. And she told you it was a Virginia slims?
21 A. She told me that is what Roger told her
22 it was.
23 Q. And who is Roger?
24 A. He was the person who was in charge of
25 the operation of the aging chamber and coordinating

1 all of the experiments that were done in that
2 chamber.

3 Q. And was he a management level employee of
4 Philip Morris?

5 A. I think you would refer to him as a
6 project leader, so that was, yes, I guess, a
7 low-level management position.

8 Q. He supervised other people at Philip
9 Morris?

10 A. Yes, he did.

11 Q. And after it was discovered that this was
12 a Virginia Slims cigarette, what if anything
13 happened?

14 A. She said she needed to discuss that with
15 the manager of Biochemical Research that was Cathy
16 Ellis.

17 Q. Spelled C-a-t-h-y?

18 A. C-a.

19 Q. Cathy Ellis. And did she discuss this
20 with Cathy Ellis?

21 A. She called her on the phone and asked
22 that she see her, and she left the office and told
23 me that is where she was going.

24 Q. Who told you that that is where she was
25 going?

1 A. Robin Kisner told me she was going to
2 talk to Cathy.

3 Q. And then what happened as far as you
4 know?

5 A. When she left, I presume, she went and
6 talked to Cathy. I went back to my office, my
7 desk.

8 Q. And did anyone communicate with you
9 further about this finding of yours?

10 A. Yes.

11 Q. Who?

12 A. Robin.

13 Q. And when did she do that?

14 A. She came back, to the best of my
15 recollection, about a half hour later, and told me
16 that Cathy had said to destroy the data and that in
17 the future we were not to run, reminded me that we
18 were not to run nitrosamines on production
19 cigarettes, and also told me that she was going to
20 remind Roger Comes that if he was going to run
21 production cigarettes in the sidestream chamber
22 that he was not to collect nitrosamines.

23 Q. If he was going to run sidestream smoke
24 on production cigarettes, he wasn't supposed to
25 collect nitrosamine levels?

1 A. That's correct.
2 Q. And do you know whether or not this was
3 communicated to Roger Comes?
4 A. I presume it was.
5 Q. Do you know whether anybody after that
6 every collected nitrosamine levels on production
7 cigarette?
8 A. Not to my knowledge.
9 Q. Did you?
10 A. Not to my knowledge.
11 Q. Did anyone else in your presence do that?
12 A. Not that I'm aware of.
13 Q. From a scientific standpoint, based upon
14 your experience as a scientist, does it make any
15 sense to destroy the data that showed Virginia
16 Slims cigarettes had ten times the nitrosamine
17 level of any of the non-production cigarettes?
18 A. From a scientific standpoint, no.
19 Q. Why?
20 A. Because it was information on a
21 production cigarette, would be my speculation as to
22 why it was destroyed, or my interpretation.
23 Q. I'm not asking why it was destroyed now.
24 I'm asking you why, as a scientist, it doesn't make
25 sense to you that that information would be

1 destroyed?

2 A. No, it didn't make sense. It doesn't
3 make -- it didn't make sense to me why it was
4 destroyed, know.

5 Q. And as a scientist, what's the reason it
6 doesn't make sense to you?

7 A. By the fact that the level was so much
8 different from what we had been getting. It was of
9 scientific interest to me to understand why and to
10 study what was -- what was the cause of this
11 increased level.

12 Q. Well, once you knew that the nitrosamine
13 on a production cigarette was ten times higher than
14 on any non-production cigarette, did you have an
15 opinion regarding whether or not the data collected
16 on the non-production cigarette was useful data,
17 the data on nitrosamine level collected on the
18 non-production cigarettes was useful data?

19 A. I think it was useful date.

20 Q. In what way was it useful?

21 A. It was useful in understanding how
22 nitrosamines are formed.

23 Q. Was it useful data in understanding the
24 effect of nitrosamines on production cigarettes or
25 the impact of nitrosamines on production

1 cigarettes?

2 A. Information that would be obtained on a
3 non-production cigarette, I don't think would have
4 any impact on understanding the production of
5 nitrosamines on a production cigarette because they
6 were completely different cigarettes.

7 Q. Do you know whether the information
8 collected on a nitrosamine level of non-production
9 cigarettes was ever used to imply in any way that
10 it was equivalent to an actual test on a production
11 cigarette?

12 A. Since we didn't have information on
13 production cigarettes, I think the general
14 assumption was that it was representative of what
15 you -- of what one would expect to obtain on a
16 production cigarette.

17 Q. And once you had done the test on the
18 Virginia Slims cigarette, did that change in any
19 way the assumption?

20 A. It did, in my mind.

21 Q. Well, do you know whether you were the
22 only one of the scientists who were involved in the
23 project who were of the opinion that assumption now
24 was questionable?

25 A. I have no basis. I would assume that

1 other people being scientists could draw the same
2 type of conclusion, but it wasn't discussed that I
3 recall.

4 Q. And when you were ordered to destroy the
5 data on Virginia Slims cigarette, what did you do?

6 A. I took the chromatograms and the paper
7 where I had tabulated or summarized the results and
8 shredded it.

9 Q. Did you ever again test an actual
10 production --

11 MR. RANGLES: Line 6.

12 MR. THOMAS: Sorry.

13 BY MR. THOMAS:

14 Q. How frequently were you ordered to
15 destroy and/or shred data that you had collected on
16 the nitrosamine levels of non-production
17 cigarettes?

18 A. Never been asked to destroy.

19 Q. Out of all of the tests that were
20 involved in measuring the nitrosamine levels of
21 cigarettes at Philip Morris, how many times did you
22 destroy or shred all of the notes concerning the
23 data?

24 A. Never.

25 Q. Well, did you do it one time?

1 A. That one time.

2 Q. Other than that one time, you didn't do
3 it any time?

4 A. No.

5 Q. Did anyone ever tell you to do it ever
6 other than that one time?

7 A. No.

8 Q. Did you ever again test an actual
9 production cigarette or cigarette you could just go
10 and buy in a grocery store?

11 A. For nitrosamines?

12 Q. Right.

13 A. Not to my knowledge.

14 Q. Did anyone at Philip Morris ever again
15 test a regular production cigarette that you could
16 buy in a grocery store?

17 A. For nitrosamines? Not to my knowledge.

18 Q. Do you know whether that particular
19 nitrosamine that you discovered, whether one way or
20 the other, whether that is present in any
21 cigarettes that exist today?

22 A. Not to my knowledge. It was only
23 discovered -- it was only found in cigarettes with
24 this particular paper on it or in these two
25 particular papers. And, to the best of my

1 knowledge, those papers aren't in production on any
2 cigarette. So, I assume it's probably not.

3 Q. So, you wouldn't able to make any effort
4 to make the Virginia Slims cigarette safer because
5 Philip Morris didn't -- and I don't mean you, I
6 mean the company, because Philip Morris didn't test
7 production cigarettes.?

8 A. I can't answer that when you use the word
9 safer because we can't say that the level that was
10 there was unsafe.

11 Q. Do you know whether or not there is a
12 safe level for nitrosamines in cigarette smoke?

13 A. I have read in the literature report
14 where they have limits have been set with respect
15 to some food products, because there are
16 nitrosamines that are in nipples on baby bottles
17 and in baby food and various things like that, and
18 there have been levels that have been set for an
19 upper limit for those nitrosamines, but those are
20 not tobacco specific nitrosamines.

21 I don't know of any work where a level
22 was actually set that was said to be a safe or
23 unsafe level with respect to tobacco-specific
24 nitrosamines.

25 Q. When you say tobacco-specific

1 nitrosamines, what do you mean?

2 A. I'm referring to the nitrosamines, NNN,
3 NAT and NNK that are formed from the alkaloids that
4 are present in tobacco.

5 Q. Do you know whether the amount of
6 nitrosamine level, if it's possible to set a level
7 for food, do you know whether it makes any
8 difference what type of nitrosamine it is?

9 A. I don't remember from the literature
10 whether they make a difference because they would
11 be looking at things like dimethylnitrosamine or
12 diethylnitrosamine or methyl ethyl or something
13 along those lines which we refer to as volatile
14 nitrosamines, which are produced during smoking of
15 cigarettes. But in mainstream smoke they are
16 effectively eliminated by the cellulose acetate
17 filter, so they're removed.

18 So those levels that were reported in the
19 literature, with relation to food products, the
20 best of my recollection that they were in the ten
21 to 20 parts per billion level.

22 Q. That's what, ten to 20, is that a
23 nanogram?

24 A. That would be the equivalent to 10 to 20
25 nanograms per gram.

1 Q. So, the literature said in food 10 to 20
2 nanograms would be the threshold level; is that
3 right?.

4 A. For those particular nitrosamines, the
5 volatiles.

6 Q. Is it possible to reduce nitrosamine
7 level in a cigarette?

8 A. Yes.

9 Q. And how do you know it's possible?

10 A. We developed methods to reduce them.

11 Q. And how do you go about reducing the
12 nitrosamine level in a cigarette?

13 A. You can reduce the alkaloid that is in
14 the tobacco by an extraction process which we
15 remove one of the precursors to the formation of
16 the pyrosynthetically formed nitrosamine.

17 You can also through an extraction
18 process reduce the pre-formed or endogenous
19 nitrosamine, which would reduce levels that go into
20 the smoke, and there are various extraction
21 processes that can be used.

22 And you could also treat filler by
23 spraying onto it say ascorbic acid, and that would
24 reduce the level of nitrosamines that were produced
25 in the mainstream smoke. I don't know about

1 sidestream. We didn't run any studies on
2 sidestream smoke.

3 Q. For reduction of nitrosamine?

4 A. For the ascorbic acid treatment.

5 The others, once you remove them from the
6 tobacco, obviously, they can't be transferred to
7 the mainstream or the sidestream. But the
8 treatments for, with the spraying of the ascorbic
9 acid, to the best of my recollection, would only
10 lock at mainstream reduction.

11 Q. On the subject of nicotine, are you
12 familiar with the term titrate?

13 A. I am familiar with that term titrate,
14 yes.

15 Q. And what is that?

16 A. It would be a method by which you would
17 achieve a certain level of component in a
18 substrate.

19 Q. Were you involved in any efforts to at
20 least attempt to do research on titration levels
21 related to cigarette inhalation and/or nicotine
22 inhalation?

23 A. I was involved in some studies to
24 determine the, their developed procedures for the
25 determination of nicotine retention as a function

1 of various inhalation parameters; how deeply you
2 inhaled; how long you held the smoke in your lungs
3 before you exhaled.

4 There was some evidence that indicated
5 that changing your smoking parameters tended to
6 change the level of retention of smoking
7 parameters.

8 Q. In lay person's terms, what does that
9 mean?

10 A. In the early, early '80s, there were some
11 studies that were done with regards to the, what
12 you refer to as the full-flavored cigarette or
13 Marlboro-type cigarette, which delivered say 15
14 milligrams of tar and a milligram of nicotine.

15 And then there were studies that were
16 done with cigarettes that were highly filtered,
17 which delivered, like a Cambridge, maybe only
18 delivered a milligram and a half of tar and a tenth
19 of a milligram of nicotine, and that people that
20 smoked those cigarettes, the low-delivery
21 cigarettes, tended to smoke them differently than
22 people who smoked a higher-delivery cigarette.
23 They would tend to take a larger puff more
24 frequently, inhale it deeper, and hold it in
25 longer.

1 Q. Do you know whether they would also tend
2 to smoke more cigarettes under those circumstances?

3 A. I think they did tend to smoke more, to
4 the best of my recollection.

5 Q. And what was the research that you were
6 involved in or attempted to implement that was
7 related to this?

8 A. This study on the way that people smoked
9 was being done by Jan Jones, and she had developed
10 a vest that you could wear that would actually
11 measure the way a person inhaled and smoked.

12 And it was a vest with a portable
13 recorder on it that could be worn all day long and
14 record those parameters. And in working with her,
15 I was to develop a procedure where we could, in the
16 laboratory, test, develop a technique where we
17 could actually measure the amount of nicotine that
18 a smoker was getting directly at the mouth, and
19 also collect the exhaled smoke and determine the
20 amount of nicotine that was retained as a function
21 of the way the person smoked, how deeply they
22 inhaled, and how long they held it.

23 And that was to, the ultimate goal was if
24 we could determine that, it was to see if a change
25 in the person's smoking habit, or parameter, if, as

1 they changed from one cigarette to another, if they
2 were tending to smoke in such a manner to maintain
3 a certain level of nicotine. That was the goal.

4 I developed the analytical technique for
5 measuring the amount of nicotine that was absorbed
6 as a function of the way the person smoked. But we
7 never -- the project was terminated at that point.
8 So we never actually did the test on various
9 subjects to determine what the actual rate of or
10 amount of nicotine absorption was corresponded with
11 the way a person smoked.

12 Q. Approximately what year was that?

13 A. '81 or '82, somewhere in that general
14 range.

15 Q. Did you, yourself, have any occasion to
16 test the vest?

17 A. Yes, I did.

18 Q. And what did you find, if anything?

19 A. I just wore it to, when she was
20 developing the vest, initially, initially, what she
21 did, she had electrodes that she would just place
22 on the body. They were hooked up to an extremity,
23 and then once she saw that you she could get the
24 readings and she knew where to place the
25 measurement, the electrodes, then she incorporated

1 them into the vest and tied them into a recorder.
2 And so I had -- I had worked with -- not with her,
3 but was the test subject that she used to measure,
4 and I wore, not only the electrodes put on me, but
5 also wore the vest to see how well it worked.

6 Q. And what did you find out?

7 A. It worked.

8 Q. And after you discovered that that vest
9 would work, what happened?

10 A. Actually, during the time that we were
11 testing and developing the vest, she had -- Jan had
12 corresponded to me the, what the objective of that
13 study was.

14 And so I suggested that why didn't we
15 develop, see if we could develop a method to
16 correlate nicotine absorption with smoking
17 parameters and, therefore, we could tie that in
18 with what she obtained from her studies.

19 And that puzzle was put forth to
20 management. They approved that we could go forward
21 with developing the technique; and once the
22 technique for the measurement of the nicotine
23 retention was developed, that is when the project
24 was terminated.

25 Q. Do you know who made the decision to

1 terminate the project?

2 A. No. I know who her manager was.

3 Q. Jan Jones?

4 A. Jan Jones' manager.

5 Q. Who was that?

6 A. Bill Dunn, and that his director was Tom
7 Osdene; but who made the decision, I don't know.

8 Q. I'm showing you what has been marked as
9 Plaintiffs Exhibit 6, which is a copy of an article
10 that was in U.S.A. Today, April 24, 1997. And I
11 would like you to look at that and just read the
12 article. It's not very long. And after you read
13 it let me know that you have read it, and I'll ask
14 you a few questions.

15 Have you had an opportunity to read it?

16 A. Yes, I have.

17 Q. Does that article refer to one of the,
18 for want of a better term, one of the hypotheses
19 that you and/or Jan Jones had when you initially
20 proposed the research study related to the use of
21 the vest?

22 A. I don't think it refers to hypothesis. I
23 think she had preliminary findings that suggested
24 that people tended to smoke the lower-delivery
25 cigarettes more than they smoked the

1 higher-delivery cigarettes, by increasing the depth
2 of inhalation, the retention time that they held
3 them and taking actually larger puffs and more
4 frequent puffs.

5 Q. What kind of research did she use to
6 obtain those preliminary findings?

7 A. She had -- she had people wear the vest
8 and also come into her lab, and she had them smoke
9 cigarettes that were unknown to them as to whether
10 they were high-delivery or low-delivery cigarettes,
11 and from the results of those studies that is what
12 she found.

13 Q. And how did you become aware of the
14 studies that Jan Jones had done, the preliminary
15 studies?

16 A. I was doing some work up on the floor
17 that she was on. I was also a social friend of
18 hers and was aware of the work that she was doing,
19 and during the development of this, her measuring
20 procedure, she would ask me if I would participate
21 as a test subject.

22 Q. Referring to the second paragraph of this
23 article, it says, quote, "To compensate for lower
24 nicotine levels, smokers now typically smoke more
25 cigarettes per day than in the 1950s and 1960s,"

1 end quote.

2 Now, did Jan Jones' preliminary studies
3 back in 1981, '82 time period that indicated that
4 that may be true?

5 A. I can't answer that. All I know is that,
6 is that she studied the way people smoked at that
7 time, and she knew that a person that was smoking a
8 high-delivery cigarette smoked one way and a person
9 that smoked a lower-delivery cigarette tended to
10 smoke a different way.

11 Q. When you say a high-delivery cigarette,
12 what do you mean?

13 A. Something delivered, it was equivalent to
14 a Marlboro say 15 milligrams of tar and a milligram
15 of nicotine. And a low-delivery would be relative
16 to say a Cambridge or something that would produce
17 a milligram and a half tar and a tenth of a
18 milligram of nicotine.

19 Q. Did the preliminary studies indicate that
20 people compensated for the lower levels of nicotine
21 by taking in more smoke and puffing for longer
22 periods of time or do you know?

23 A. They indicated that they took larger
24 puffs, inhaled it deeper, and held it longer. And
25 the proposal that I had made was to study what the

1 retention of nicotine was in order to determine if
2 that is what they were doing.

3 Q. If the findings showed what this
4 particular article indicates, assuming this article
5 is accurate, would those findings have been
6 scientifically useful findings back in 1982?

7 A. I think they would have been.

8 Q. Do you know whether or not Philip Morris
9 conducted any research involving mouse skin
10 painting?

11 A. I heard that they did.

12 Q. And how did you hear that they did?

13 A. Through discussions that were carried on
14 at Philip Morris.

15 Q. What was the nature of those discussions
16 that were carried on at Philip Morris?

17 A. They had developed a group to deposit
18 biological activity studies using an Ames assay and
19 the word or the information that was made available
20 to me through discussions was that the results that
21 they were obtaining for the Ames assay tests were
22 equivalent to the results that they had obtained
23 from the mouse skin painting test with relation to
24 the biological activity of the smoke samples they
25 were testing.

1 Q. And by biological activity, what do you
2 mean?

3 A. In the Ames assay it would be the
4 inhibition of the growth of the salmonella cells,
5 and in mouse skin painting it would be the
6 production of some physiological response to it.
7 Say the development of a tumor.

8 Q. And what individuals were involved in
9 those studies, if you know any of them?

10 Hold it.

11 A. It was my understanding --

12 THE COURT: Hold on.

13 MR. THOMAS: Just one moment.

14 BY MR. THOMAS:

15 Q. And what individuals were involved in
16 those studies, if you know any of them?

17 A. It was my understanding that the studies
18 were done in Europe, in Germany, on the mouse skin
19 painting. And I think the initial tests of the
20 development of the Ames assay were developed there,
21 also. And the person that was coordinating that
22 work at Philip Morris was Jim Charles or Tom
23 Osdene.

24 Q. And do you know if any of their findings
25 were published?

1 A. Not to my knowledge. I mean, I don't
2 know.

3 Q. Do you know any of the results of that
4 research?

5 A. Only what I stated, that they actually
6 had a program there at -- here in Richmond at the
7 research facility where they were doing the Ames
8 assay studies, and that the results they were
9 getting were equivalent to the results that they
10 got from the mouse skin painting.

11 Q. The program that you and Jan Jones, the
12 research proposal that you and Jan Jones had made
13 and the protocol for that proposal that you
14 developed with reference to that, do you have any
15 opinion as to why it wasn't implemented?

16 A. I have an opinion.

17 Q. And what is that opinion?

18 A. That management didn't want to know the
19 answer.

20 Q. Do you have an opinion as to why they
21 didn't want to know the answer?

22 A. No, I don't.

23 Q. Do you have a hypothesis of what the
24 answer would have been had you done the research?

25 A. I have a hypothesis, yes.

1 Q. And what was that?

2 A. That we would have found that people
3 would have, if they took larger puffs and inhaled
4 it deeper, held it longer, they would absorb more
5 nicotine, that the preliminary results that she had
6 obtained, Jan had obtained, which indicated that
7 that is the way people were tending to smoke when
8 they went from high-delivery cigarettes to
9 low-delivery cigarettes, the conclusions I believe
10 would have been that people were tending to titrate
11 themselves to a certain level of nicotine.

12 Q. Were you ever told to edit scientific
13 reports to omit reference to subjects that might be
14 considered sensitive?

15 A. Can you be more specific about sensitive?

16 Q. Might have a tendency to show or indicate
17 that cigarettes or cigarette smoking may be harmful
18 to those who consumed the product either
19 voluntarily or involuntarily?

20 A. We were instructed not to include
21 reference to potential health effects in our
22 reports on discussions of results, and we were told
23 the reason for that was that they were not
24 measuring or not studying the health effects.

25 We were only to reporting the data that

1 we collected as far as concentration of a
2 particular component that we measured. So,
3 therefore, that is the only thing we should report.

4 Q. Do you know whether Philip Morris ever
5 attempted to duplicate studies done by researchers
6 outside of the tobacco industry?

7 A. Yes, I did.

8 Q. And do you know whether they were able to
9 successfully duplicate any studies that were done
10 outside the tobacco industry that were related to
11 tobacco?

12 A. Yes, they were.

13 Q. What studies do you know of that they
14 were able to duplicate?

15 A. Various -- we had a protocol for our
16 collection methods and our sample preparations or
17 workup methods and analysis methods, and
18 occasionally people at either a university or
19 somewhere like say the American Health Foundation
20 or some non-tobacco facility would publish a paper
21 indicating that they had an improved method for the
22 analysis, and we would duplicate as close as we
23 could that particular procedure to see if it was
24 really an improvement over the method that we were
25 using.

1 Q. And if it was an improvement, what would
2 happen, if anything?

3 A. If it was an improvement, we would have
4 probably adopted it for our use.

5 Q. How would you characterize the resources
6 that were made available to you as a scientist to
7 carry out research requested by Philip Morris?

8 A. I would characterize them as being very
9 good. We always had the best that was available.

10 Q. Did the cost of the equipment or
11 personnel to your knowledge prevent Philip Morris
12 from doing research that they, the company, wanted
13 to do?

14 A. I don't 0I couldn't answer that, because
15 I don't know what they might have turned down. All
16 I know is if we requested improved instrumentation
17 or the necessity for expertise in the way of a
18 consultant, and we could justify that, it was
19 usually provided to us.

20 Q. What was the reason given for not
21 allowing you and Jan Jones to implement your
22 project related to the use of the vest to measure
23 inhalation patterns?

24 A. I wasn't given a reason.

25 Q. And approximately what year did that

1 occur?
2 A. In the early '80s, '82, '82.
3 Q. Now you left the company sometime in
4 1992; is that correct?
5 A. That's correct.
6 Q. Approximately what month was that?
7 A. I left in July of '92.
8 Q. And why did you leave?
9 A. I was fired.
10 Q. Do you have an opinion as to the reason
11 you were fired?
12 A. I was told that the project was being
13 transferred overseas and I no longer had a job.
14 Q. What project?
15 A. The nitrosamine projects.
16 Q. Prior to the time that you were told you
17 no longer had a job, had you received any
18 unsatisfactory work evaluations?
19 A. No, I hadn't.
20 Q. What kind of work evaluations did you
21 receive during the 20 years that you worked for
22 Philip Morris?
23 A. Either evaluations that met the
24 requirements of my position or exceeded the
25 requirements of my position.

1 Q. Well, did you offer to go overseas where
2 the project was going to be relocated?

3 A. Yes, I did.

4 Q. What, if anything was the response to
5 that?

6 A. I was not offered a position over there.

7 Q. Have you in the past or are you currently
8 suffering from any --

9 MR. RANGLES: Um --

10 MR. THOMAS: I'll let him read that.

11 THE COURT: Go ahead, Mr. Randles.

12

13 CROSS-EXAMINATION

14

15 BY MR. RANGLES:

16 Q. Have you in the past or are you currently
17 suffering under any mental or physical conditions?

18 A. I have an anxiety problem that I take
19 medication for.

20 Q. What's the nature of the anxiety problem?

21 A. It's referred to as an endogenous
22 anxiety, which also has affiliated with it some
23 agoraphobia.

24 Q. What's agoraphobia?

25 A. It's fear of being in public places, and

1 also other phobias that are associated with it
2 where I've had anxiety attacks before, say if I
3 were in a restaurant or whatever and I had an
4 anxiety attack in that restaurant, I would maybe
5 have a phobia of returning to that particular
6 restaurant.

7 Q. What triggers anxiety attacks in you?

8 A. It's a, as conferred to me by my doctor,
9 it's a chemical imbalance in the brain and I think
10 related to serotonin and it's, it's not really what
11 I think -- it's treated mostly by psychiatrists,
12 but it's more of a physiological disorder such as
13 diabetes, because it can be triggered by lactic
14 acid. So if I were to be given an injection or
15 dose of lactic acid, it could trigger an attack.

16 Q. Can a stressful even trigger an attack?

17 A. I guess it's possible, yes.

18 Q. But it hasn't in you, as far as you are
19 aware?

20 A. It may have. I can't really say.

21 Q. How long have you been under medication
22 for that condition?

23 A. Probably for maybe 15 years or more.

24 Q. So, if my math is right, it's 1997, so
25 since approximately 1982?

1 A. Early '80s, yes.
2 Q. So, prior to changing jobs at Philip
3 Morris and going over to the Biochemical Research
4 Division; correct?
5 A. Yes.
6 Q. Do the medications have any side effects?
7 A. Some do. Some don't.
8 Q. So you're different medications; is that
9 right?
10 A. Currently, I'm on just one regime,
11 medication regime, but over the years I have tried
12 different medications to see which one worked best,
13 because of the pills, some of the side effects,
14 some make you drowsy, some would make you hyper,
15 that type of reaction.
16 Q. What medications were you on in the late
17 1980s?
18 A. Probably Clonopin and I may have still
19 been taking some Ativan at that time, but both are
20 benzodiazepine, as far as class of drug.
21 Q. What side effects would those drugs have?
22 A. Various ones have different side effects.
23 Q. Those two drugs that you were taking in
24 the late 1980s, what side effects would they have?
25 A. It would depend on the individual.

1 Q. With you?

2 A. They seemed to would work fairly well.
3 That's the reason I was taking them. The
4 benzodiazepine class of compounds also includes
5 Valium, Xanax, various other, there's a whole host
6 of them, and some of them, like I say, I would
7 produce the anxiety -- increased level of anxiety
8 and some would produce too much sedation or make
9 you drowsy.

10 Q. So how about those two that you were
11 taking in the late '80s? What were their side
12 effects on you?

13 A. Effectively minimal.

14 Q. Drowsiness?

15 A. Not a noticeable amount, no.

16 Q. Would they have any impact upon your
17 ability to assess a situation, understand what was
18 going on, et cetera, et cetera?

19 A. No.

20 Q. No?

21 A. Not to my knowledge.

22 Q. Were you under the care of a psychiatrist
23 in the late 1980s then?

24 A. Yes, I was.

25 Q. So in the late 1980s you're under the

1 care of a psychiatrist and you're being medicated
2 for it, what would you call it, a psychiatrist
3 condition at that time; is that correct?

4 A. It was classified as that, because I was
5 being treated by a psychiatrist. .

6 Q. Did your condition require extensive
7 medical leave from work?

8 A. I took a medical leave of absence in
9 1990, because I was having a, I guess I had, you
10 might say, an acute attack of anxiety, and was out
11 from four and a half months, from June to the
12 middle of the October.

13 Q. And that was in 1990?

14 A. Yes.

15 Q. Do you know how early -- I'm story. I
16 missed the dates in 1990.

17 A. It was in early, early to middle June,
18 till about the middle of October. I have the
19 records from Philip Morris on the approval of my
20 medical leave of absence and my return to work, if
21 you want.

22 Q. Let me get back to that, if you want --
23 but it's not necessary at this point.

24 The symptomatology that required you to
25 take the medical leave in 1990, when did that begin

1 to manifest itself?
2 A. When?
3 Q. Yes.
4 A. It just came on very suddenly.
5 Q. So you were employed -- let me just ask a
6 couple more questions. Did the anxiety condition
7 itself have any impact on your ability to assess
8 situations as they occurred, you know, accurately
9 perceive what is going on in your surroundings,
10 anything of that variety?
11 A. I don't believe so.
12 Q. Let me just read this to you and see if
13 this begins to describe some of the work you were
14 doing, and I'm quoting.
15 "Initiated, planned and conducted studies
16 related to the origin identification and
17 quantification of sub trace components of
18 proprietary interest in tobacco and tobacco smoke,
19 including ETS."
20 Is that an accurate description of some
21 of the things you were doing in '98 through your
22 completion of your employment at Philip Morris in
23 1992?
24 A. Yes.
25 Q. When you talk about the quantification of

1 sub trace components, what components would you be
2 referring to?

3 A. Nitrosamines.

4 Q. And what does sub trace mean?

5 A. It's just a general reference to, if you,
6 I think generally in analytical chemistry, if you
7 are referring to levels down into part per million,
8 and maybe a little bit higher, you would call them
9 trace levels.

10 If you were talking about sub part per
11 million, part per billion, or maybe even part per
12 trillion, you would call them sub trace.

13 Q. So, we are talking about TSNAs or just
14 tobacco-specific nitrosamines in tobacco smoke,
15 whether it's sidestream or mainstream smoke, we are
16 talking about extremely minute levels; aren't we?

17 A. We're talking about parts per million,
18 yes.

19 Q. Parts per billion. Because of the very
20 small number of those components in cigarette
21 smoke, is it difficult to collect and measure those
22 components?

23 A. No.

24 Q. Is it easy?

25 A. It wasn't as easy as doing some

1 experiments, but it wasn't difficult, what I would
2 consider difficult.

3 Q. You need sophisticated equipment?

4 A. You would need specialized equipment,
5 yes.

6 Q. And the margin of error is very small
7 with that sophisticated equipment; is it not?

8 A. I don't know what you mean by margin of
9 error.

10 Q. I mean the smallest variation in
11 procedures could throw off the numbers in a
12 meaningful way; is that correct, in using that sort
13 of machinery?

14 A. Well, there's a lot of steps. There is a
15 collection step, which has an air level associated
16 with it.

17 And then there's the extraction from the
18 device you collected it in its workup and
19 concentration, which can have an error associated
20 with it, and then there's the actual instrumental
21 part where you actually analyze the concentration
22 in the prepared sample, which has a margin or
23 error, and I would say that the instrumental part
24 of it is probably the most precise.

25 Q. And in this section I have read to you

1 say sub trace components of proprietary interest,
2 so you are describing there that Philip Morris
3 would have the proprietary interest in TSNA work
4 you were doing; correct?

5 A. Yes.

6 Q. It was never your role at Philip Morris
7 to evaluate the health effects, if any, of
8 environmental tobacco smoke, was it?

9 A. I'm sorry. No, I'm not.

10 Q. It was never your role to evaluate the
11 health effects, if any, of nitrosamines in
12 mainstream smoke; correct?

13 A. No, I'm not.

14 Q. And you're not qualified to offer expert
15 opinions on those topics, are you?

16 A. I have a knowledge of what's published in
17 the literature, and I can offer opinion on that.
18 As far as ever doing any experiments on health
19 effects, I have never had none.

20 Q. You are not an expert in mouse skin
21 painting, are you?

22 A. No, I'm not.

23 Q. Not an expert in Ames assays, are you?

24 A. No, I'm not.

25 Q. You are not an expert in human smoking

1 behavior, are you?
2 A. No, I'm not.
3 Q. And specifically, you are not an expert
4 in the nicotine titration hypothesis, are you?
5 A. Being an expert in hypothesis is kind of
6 a contradiction in terms; isn't it?
7 Q. It's really not. Are you an expert in
8 nicotine theories?
9 A. I'm an expert in, I would classify myself
10 as being an expert in developing analytical
11 procedures that could determine or support a
12 hypothesis.
13 Q. But you're not an expert in the
14 literature that deals with the nicotine titration
15 hypothesis?
16 A. It's not published in the literature. I
17 never published it. So --
18 Q. Right. But you're aware of the body of
19 literature on the nicotine titration hypothesis?
20 A. I'm aware of some of it, yes.
21 Q. But not all of it?
22 A. I doubt that I read it all.
23 Q. How many articles would you say you have
24 read on it?
25 A. I wouldn't hazard a guess.

1 Q. Are you an expert in carcinogenesis?
2 A. No, I'm not.
3 Q. Are you an expert in tobacco-specific
4 nitrosamine-related carcinogenesis?
5 A. No, I'm not.
6 Q. Are you an expert in nitrosamine
7 carcinogens?
8 A. No, I'm not.
9 Q. You would agree with me, wouldn't you,
10 that the scientists you work with at Philip Morris
11 were highly qualified, wouldn't you?
12 A. Yes, sir.
13 Q. And you would agree with me that the work
14 done by yourself and others in Philip Morris'
15 Research and Development area was good science;
16 wouldn't you?
17 A. Yes.
18 Q. And you would agree with me that the work
19 that you did at Philip Morris, as well as the work
20 that was done generally in R&D or Research and
21 Development at Philip Morris was well-supported;
22 correct?
23 A. Supported in which way?
24 Q. With regard to the equipment provided?
25 A. Yes.

1 Q. With regards to the working space
2 provided?
3 A. Yes.
4 Q. With regards to resources generally?
5 A. Yes.
6 Q. And like you had said a few minutes ago
7 on direct-examination, when you asked for resources
8 or consultants, consultants or equipment, what have
9 you, you got it if you could justify it; correct?
10 A. That's correct.
11 Q. And there might be all sort of reasons
12 why Philip Morris would choose not to approve
13 research requests no matter how ardently the
14 proponent of the request might have held it; isn't
15 that true?
16 A. That is true.
17 Q. It could be just a simple question of
18 priority, couldn't it?
19 A. That's possible.
20 Q. It could be a question of money, couldn't
21 it?
22 A. It's possible.
23 Q. It could be that Philip Morris chooses
24 not to conduct certain research because it's
25 already well enough established in the external

1 literature; correct?
2 A. That is possible.
3 Q. It could be that Philip Morris would
4 choose not to approve requested research for the
5 reason that it wasn't sufficiently
6 business-related; correct?
7 A. That is possible.
8 Q. Did you consider Philip Morris a good
9 place to work?
10 A. Yes, I did.
11 Q. Did you consider the assignments and the
12 work you did challenging?
13 A. Yes.
14 Q. Interesting?
15 A. Yes.
16 Q. Is it accurate to say that while you were
17 at Philip Morris you published two papers in the
18 outside literature, in the available scientific
19 literature, that related to the work you were doing
20 at Philip Morris?
21 A. That's correct.
22 Q. Also it would be correct to say you made
23 six presentations concerning the work that you did
24 at Philip Morris to groups that were open to the
25 general public?

1 A. That I actually presented myself or was I
2 just a co-author to the presentation?
3 Q. Either a presenter or as a co-author?
4 A. Six.
5 Q. Those were with regard to the six
6 publications -- I'm sorry, the six presentations
7 and the two publications that those were scientific
8 topics; correct?
9 A. Yes, they were on scientific topics.
10 Q. And they were important scientific
11 topics, were they not?
12 A. To me they were, yes.
13 Q. And they were based upon work that you
14 had done at Philip Morris; correct?
15 A. Yes.
16 Q. And Philip Morris allowed you to make
17 those presentations and to publish those
18 publications; correct?
19 A. Yes, they did.
20 Q. They encouraged you to do it, didn't
21 they?
22 A. Yes, they did. I would add that in the
23 early part of my tenure at Philip Morris from '72
24 probably on to the early '80s, Philip Morris
25 encouraged you to take 20 to 25 percent of your

1 time and work outside of our assigned area of
2 research such that you come become involved with
3 what other people were doing, expand your knowledge
4 of other thing that were going on in the company
5 and develop expertise, and also to follow ideas
6 that you might have, and they encouraged that.

7 As far as the studies with Jan Jones,
8 that is how I got involved and that is how that
9 time was allocated for that project.

10 Q. And Philip Morris' interest in that was
11 to make you a better scientist, more rounded
12 scientist; correct?

13 A. That's correct.

14 Q. And to make Philip Morris a better
15 company scientifically by allowing that interaction
16 of cross disciplines; correct?

17 A. That's correct.

18 Q. Now, I notice in some of the publications
19 and presentations you ha co-authors from the
20 company.

21 You had Jerry Whidby as a co-author?

22 A. That's correct.

23 Q. Good scientist, Jerry Whidby?

24 A. Good scientist.

25 Q. How about Tom Osdene, he was a co-author

1 on some of those presentations and papers; was he a
2 good scientist?

3 A. I would presume he was.

4 He was, he was already a director when I
5 joined Philip Morris. So, he was not actually
6 working at the bench publishing papers. He was
7 drawing from the work that others had done and
8 would present them at meetings.

9 So I had no way of really evaluating his
10 scientific knowledge or scientific ability at the
11 bench. His knowledge of science I would judge as
12 being very good.

13 Q. What about Vicky Baliga; am I saying that
14 right?

15 A. Baliga.

16 Q. Vicky Baliga, would you consider her a
17 good scientist?

18 A. Yes, I would.

19 Q. Now, you had some pre-Philip Morris
20 publications and presentations; did you not?

21 A. Yes, I did.

22 Q. And those were for the same purpose, to
23 share information from the scientific community;
24 correct?

25 A. That's correct.

1 Q. Now, if I asked you this before, I
2 apologize, the publications and presentations you
3 had made based upon work you had done at Philip
4 Morris that was for the purpose of sharing
5 information with the external community, scientific
6 community; correct?

7 A. Yes.

8 Q. The same is true for these pre-Philip
9 Morris publications and presentations, you were
10 sharing information with your colleagues in the
11 scientific community; correct?

12 A. That's correct. I will go back and make
13 an addition to one of the presentations which is
14 presentation number four, which was to the College
15 of William and Mary Graduate Seminars Series.

16 Q. Yes, sir.

17 A. That referred to the nuclear magnetic
18 resonance work that I did when I was in graduate
19 school. But the purpose of getting involved with
20 that program was to have an interaction with the
21 external scientific community and with the people
22 at William and Mary.

23 Q. Very good.

24 The pre-Philip Morris publications and
25 presentations involved Don Leyden; correct?

1 A. That's correct.
2 Q. In other words, he was a co-author and
3 company presenter with you on some of those
4 presentations; correct?
5 A. That's correct.
6 Q. Than Don Leyden is another good
7 scientist?
8 A. Very good scientist.
9 Q. And when you met Don Leyden, where was
10 he?
11 A. He was my major professor when I was in
12 graduate school.
13 Q. And did Don Leyden eventually become an
14 employee of Philip Morris?
15 A. Yes, he did.
16 Q. And the work that he at Philip Morris
17 continued to be excellent as it was before he was a
18 Philip Morris employee; correct?
19 A. That's correct.
20 Q. Let me ask you a few questions, if I can,
21 please, about the smoking vest project. That was
22 primarily Jan Jones project; is that correct?
23 A. That's correct.
24 Q. And you provided some technical
25 assistance in developing some methodologies; is

1 that correct?

2 A. Yes. She was developing the vest for
3 studying just the way to be able to measure the way
4 people, their smoking patterns, inhalation
5 patterns, and she had asked me if I would help her
6 with some of the early tests on the vest and just
7 testing it out, which I did. I guess you could say
8 I might have been a model.

9 Q. You were a subject?

10 A. Or a subject, yes. And I wore it for
11 comfort and also wore it to test how accurately it
12 measured inhalation parameters, because she had an
13 instrument there that you could, she would say,
14 take a certain size puff and draw it deep into your
15 lungs and it would measure the volume that you
16 took, and so she would correlate that with what she
17 was measuring on her instrumentation.

18 Q. But you didn't smoke any cigarettes while
19 you were wearing the vest, did you?

20 A. No, I didn't.

21 Q. Did you see any results of
22 experimentation that she did to see whether people
23 who were smoking with the vest were generating data
24 and results that were to her valid and
25 interpretable?

1 A. I know that she had people that smoked
2 cigarettes for her and that she had done some
3 measurements, and she told me of some of the
4 results that she had obtained.

5 Q. But you didn't see those results, did
6 you?

7 A. Not that I can recall tabulated in any
8 form.

9 Q. But you knew of those, because I think
10 you said earlier you were a social friend, you
11 worked on her floor for a bit and you were a
12 subject in some of the preliminary trials; correct?

13 A. Yes.

14 Q. Is it your sworn testimony that this
15 smoking vest was completely ready to go and to test
16 the parameters that were suggested by the study
17 that was requested?

18 A. It would be my opinion that it was fully
19 developed and ready, yes.

20 Q. And on what do you base that?

21 A. I base, the vest itself and her ability
22 and what she had developed and its ability to
23 measure inhalation parameters and that she said it
24 was fully developed.

25 As far as the part that I was going to do

1 with the collection of the inhaled nicotine and
2 exhaled nicotine and calculating nicotine
3 retention, I judge that to be fully developed and
4 ready to go.

5 Q. With regard to the vest itself and the
6 work that Jan Jones was doing, would she be a
7 better source of information in terms of readiness,
8 if you will, of that vest than you?

9 A. She would, as far as the readiness of the
10 vest.

11 Q. So, if she said the vest and the results
12 that were being generated in terms of the small
13 smoking trial that was done were generating
14 inconsistent, uninterpretable results, would you
15 have any reason to disagree with her?

16 A. If she said that, I wouldn't, no.

17 Q. Now, let's go back and make sure I
18 understand what the endpoint of this experiment,
19 the smoking vest experiment would have been. It
20 would have been, if I understand correctly,
21 nicotine retention based upon varying levels or
22 depths of inhalation; correct?

23 A. My portion of it.

24 Q. And when you testified earlier, that is
25 what you were talking about in terms of the

1 endpoint, the depth of inhalation and its affect on
2 nicotine retention; correct?

3 A. Right. She would have measured, if the
4 changes in a smoker's pattern of smoking, then
5 after, we would have gone to the lab and had a
6 number of different subjects reproduce those
7 patterns of smoking and measure their retention f
8 nicotine as a result of that, such that we could
9 correlate it back with what she had observed.

10 MR. GAYLORD: Excuse me, Your Honor.

11 Excuse me, counsel.

12 May we approach on a scheduling matter?

13 THE COURT: Sure.

14 Go back and read the previous previous
15 question and answer so that the jury can pick up
16 where you left off, please.

17 MR. RANGLES: 115, starting on line 17.

18 BY MR. RANGLES:

19 Q. And when you testified earlier, that's
20 what you were talking about in terms of the
21 endpoint, the depth of inhalation and its affect on
22 nicotine retention; correct?

23 A. Right. She would have measured, if the
24 changes in the smoker's pattern of smoking, then
25 after, we would have gone to the lab and had a

1 number of different subjects reproduce those
2 patterns of smoking and measure their retention of
3 nicotine as a result of that, such that we could
4 correlate it back with what she had observed.

5 Q. Now, in the nicotine titration literature
6 that you read, did you read that that was a
7 short-lived phenomenon when one changes from a
8 higher delivery to a lower-delivery cigarette?

9 A. Did I read that?

10 Q. Yeah.

11 A. I don't recall reading it.

12 Q. You don't remember reading it?

13 A. No.

14 Q. Do you have a distinct recollection of
15 the literature you read so long ago?

16 A. It was a long time ago, but what I recall
17 was that a large number of people, they would
18 switch to a low-delivery cigarette, they would
19 increase the number of cigarettes they smoked and
20 the way they smoked, but eventually a large number
21 of them would switch back to a higher-level
22 cigarette. That is what I recall.

23 Q. But you're not claiming to recall it all
24 or claiming to have read all the literature; are
25 you?

1 A. No, I'm not.

2 Q. Did you read any of the literature that
3 suggested that phenomenon was actually a titration
4 for tar rather than nicotine?

5 A. It's very possible.

6 Q. And you're aware of the research or are
7 you aware of the research that suggests when people
8 smoke in a different pattern, when they change from
9 high delivery to low-delivery cigarette that that's
10 a tar titration for taste rather than nicotine
11 titration?

12 A. It's possible.

13 Q. But are you aware of the literature?

14 A. Part of the study would have been to see
15 if they change their pattern of smoking with time
16 of day, with whether they were in say a stressful
17 meeting or whether they would have a casual
18 cigarette after lunch. The environmental
19 surroundings at the time was as much a part of the
20 study than anything else.

21 Q. Now, let's go back to the point of depth
22 of inhalation and nicotine retention. Did you read
23 the studies that examined that phenomenon?

24 A. Read studies that did it?

25 Q. Yes.

1 A. I don't recall any offhand.

2 Q. Do you recall -- so you don't recall
3 reading studies that began back in the 1920s that
4 examined nicotine retention as a function of depth
5 of inhalation?

6 A. I don't recall, no.

7 Q. If there was literature that thoroughly
8 investigated that phenomenon, beginning in the
9 1920s, could that be one reason Philip Morris chose
10 not to pursue the smoking vest study?

11 A. That could be a reason, yes.

12 Q. And you're not aware whether that
13 literature exists, are you?

14 A. No, I'm not.

15 Q. And you earlier testified that it was
16 your opinion that Philip Morris didn't want to know
17 the answer with regard to this research; correct?

18 A. That was my opinion, yes.

19 Q. And you don't know whether Philip Morris
20 knew about the external literature that focused on
21 this very concept that you wanted to test; correct?

22 A. That's correct.

23 Q. So, if they knew of all of this
24 literature that was out there that had already
25 thoroughly examined what you were proposing to

1 test, that would have been a good reason not to do
2 your experimentation, wouldn't it?

3 A. It would have been, but I would have
4 thought that when the proposal was first put to
5 them to develop the technique to measure that they
6 would have said no at that point, rather than to
7 spend the time to develop the technique and then
8 say no.

9 Q. But it would be a very good reason if
10 that literature was out there not to approve your
11 project; is that correct?

12 A. That's correct.

13 Q. And when you say that Philip Morris
14 didn't want to know the answer, you'll agree with
15 me that that is just speculation on your part;
16 correct?

17 A. That's correct.

18 Q. And when I talk about they didn't want to
19 know the answer, when you offered the opinion
20 Philip Morris didn't want to know the answer, with
21 regard to your end of the experimentation, inhale,
22 and retention, that was just speculation on your
23 part; correct?

24 A. Correct.

25 MR. RANGLES: Your Honor, this would be a

1 good place for a break.
2 THE COURT: Jurors, we'll take the
3 morning recess now. And then we are going to
4 interrupt this cross-examination reading in favor
5 of a live witness. This will be continued in due
6 course.
7 Leave your notes on the chair, please.
8 Don't discuss the case. Watch your step. 15
9 minutes, please.
10 Anything for the record?
11 MR. GAYLORD: No, Your Honor.
12 THE COURT: 15 minutes.
13 * * *
14 (Whereupon, after a recess, the proceedings
15 continued, as follows:)
16 * * *
17 THE COURT: Bring them in, please.
18 Mr. Gaylord.
19 MR. GAYLORD: Thank you, Your Honor.
20 Plaintiff will call Dr. James Kern.
21 THE COURT: All right.
22 THE CLERK: Step right up to the chair,
23 Doctor, and remain standing.
24 Raise your right hand.
25

1 DR. JAMES KERN

2 was thereupon called as a witness on behalf of the
3 Plaintiff and, having been first duly sworn, was
4 examined and testified as follows:

5

6 THE CLERK: Please be seated.

7 And, Doctor, I need to have you go as far
8 to the right as you can, without rolling over
9 there. And then we can get this. This is for a
10 line of sight problem. But we have the jurors
11 close to the wall. They need to be able to see,
12 as well as hear you.

13 THE WITNESS: Okay.

14 THE CLERK: Thank you.

15 And please state your name. Spell your
16 first name and your last name.

17 THE WITNESS: My name is James M. Kern.
18 The first name is J-a-m-e-s. The last name is
19 Kern, K-e-r-n.

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DIRECT EXAMINATION

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BY MR. GAYLORD:

Q. Dr. Kern, I have an ambition to try to get through this material with you this morning and get you back to your practice. I don't know how realistic that is, but I'm going to try. So I'm going to try to move along quickly.

I want you to first explain to the jury what kind of doctor you are and what your educational background is to qualify you in that field?

A. I'm a physician of internal medicine, practicing here in Oregon for the last 18 years. I have been at the Metropolitan Clinic, now called Health First Medical Group.

My training in medicine, excuse me, was in the State University of New York at Buffalo with a degree in medicine. And my post-graduate training in internal medicine, residency, was in Minneapolis, Minnesota, at the County Medical Center there.

Q. The Metropolitan Clinic, now called Heath First, is located over by the Coliseum, Rose Garden, over on Broadway?

1 A. That is the office that I practice in.
2 We have several offices around Portland.

3 Q. And you are a --

4 THE CLERK: Line of sight problem,
5 counsel. Sorry.

6 MR. GAYLORD: Thank you.

7 BY MR. GAYLORD:

8 Q. You are a physician who, in your
9 practice, became acquainted with and treated the
10 late Jesse Williams?

11 A. Yes, I did.

12 Q. Internal medicine is the specialty that
13 you are in. And could you just briefly tell the
14 jury what that means? What that is?

15 A. We have a lot to do with diagnosis and
16 caring for people with a variety of illnesses,
17 sometimes related to blood pressure problems,
18 diabetes, lung disease, heart disease, a variety of
19 the internal organs.

20 I think that is where the term really
21 originated, was we deal with the internal part of
22 the body and how it worked.

23 So we do not do surgery, typically. We
24 do diagnosis and prescribe medication and other
25 forms of therapy.

1 Q. And in your practice with Health First,
2 at that particular clinic, are you one of a large
3 group of physicians who cover various different
4 specialties so that you can provide sort of a
5 full-service clinic to patients?

6 A. We have a number of surgical and medical
7 sub specialists.

8 Q. And you were one of the physicians who
9 saw Jesse Williams over a period of time, kind of
10 as his general or family doctor?

11 A. Right. I think it would be fair to say I
12 was his primary care doctor or during the time of
13 1991 to 1996.

14 Q. Sometimes, during that time, he saw one
15 of your partners instead of you for various
16 reasons, but you were his primary care physician?

17 A. That's correct.

18 Q. And are you board certified in internal
19 medicine?

20 A. Yes, I am.

21 Q. And that is the national standard tests
22 that are performed in order to qualify you to call
23 yourself a specialist in that field?

24 A. That's right.

25 Q. And were you in particular involved in

1 the ultimate diagnosis of Jesse Williams' lung
2 cancer in 1992?

3 A. Yes, I was.

4 Q. I want to go through a little bit of the
5 history of Jesse Williams' medical care with your
6 group including your contacts with him but also
7 what you learned and were aware of from his
8 existing records when he came into your care.

9 Let me mention, Your Honor, if I may, the
10 medical records, certainly not every medical record
11 in his life, but the pertinent portions of his
12 medical records for Jesse Williams are in evidence
13 in a couple of different forms, just so the jury
14 can make their notes on that.

15 Plaintiff's Exhibit 164 is part of those
16 records, kind of, from the time of diagnosis of his
17 cancer on through the rest of his life and maybe a
18 little before that.

19 Defendant's Exhibits 882 to 896 I think
20 are the portions that they have submitted and
21 designated. And I think Page 918 or Exhibit 918 of
22 Defendant's we agreed were left out and got added
23 in later.

24 So that combination of exhibits is where
25 the jury will look for the medical records that

1 we'll be talking about.

2 THE COURT: Thank you, Mr. Gaylord.

3 BY MR. GAYLORD:

4 Q. And you have your charts with you,
5 Doctor?

6 A. I do.

7 Q. And if you need to look anything up or
8 get to a page to talk about any of the things that
9 I'm going to ask you about, feel free to do that.
10 This is not a memory test.

11 A. Good.

12 Q. All right.

13 What did you -- when was your first
14 involvement in Jesse Williams' medical care?

15 A. My involvement was on 10/28/91.

16 Q. Okay. And I'll find that page of these
17 charts, page 305 of the exhibits. There are Bate's
18 numbers on most of the pages at the bottom corner.
19 So, Defendant's 889.

20 And at that time did you scan through
21 prior records for Jesse Williams' care and learn
22 kind of a background of his history and who he was
23 so that you could be up-to-date on him medically
24 when you saw him?

25 A. Yes.

1 Q. I don't want to go in detail through that
2 prior medical history, but I want to just establish
3 a couple of issues that might have happened in his
4 prior history.

5 Did you become aware when you saw Jesse
6 Williams in October of 1991 that he had a long-term
7 smoking dependency?

8 A. Yes, I did.

9 Q. Did you also become aware that he had a
10 history of recurrent coughs and bronchitis-type
11 conditions and colds?

12 A. Yes, I did.

13 Q. And what were you seeing him for in that
14 October 1991 visit?

15 A. Well, he chiefly came in because he had a
16 persistent cough over a number of months and was
17 concerned about that. He had been feeling somewhat
18 tired as well, and that was really the primary
19 reason for the visit, was the fatigue and the
20 persistent cough.

21 Q. Okay. Now, I think I want to skip
22 forward to the later end of this period of time,
23 and we'll catch up the in-between time as we go.

24 When was the lung cancer diagnosis made
25 in Jesse Williams' case?

1 A. That was made in October 1996.

2 Q. Okay. And was it late September and
3 early October when the pieces of the puzzle were
4 falling together to give that diagnosis?

5 A. Yes, that's correct.

6 Q. In that Fall of 1996 time period, I want
7 to work backwards just to kind of put some context
8 on what led up to that diagnosis, as the next goal
9 I have here, had you seen Jesse Williams on June
10 27th, 1996, if I'm not mistaken?

11 A. That's correct.

12 Q. For ready reference in these charts, I'm
13 aware that your notes in the charts are generally
14 typed up?

15 A. That's correct.

16 Q. That's your practice of how you make a
17 chart note?

18 A. Correct.

19 Q. And, as I see the chart, it looks like
20 you're the only one that had that as a usual
21 practice. The occasional contacts, phone calls to
22 the nursing staff or contacts with other physicians
23 are usually handwritten in here?

24 A. Yes. The phone notes are typically
25 handwritten, and there are occasional notes from

1 interactions with some of my other partners that
2 are handwritten.

3 Q. Okay. I think in our record, Bate's No.
4 Page 291, Exhibit 884, is the page for June 27th,
5 1996.

6 Let me just put some of these dates so
7 that we can kind of keep a mental image of them.

8 On that date were you seeing Jesse
9 Williams for a problem that had been noted in some
10 earlier visits in that year and then seemed to have
11 subsided and now he was back with follow up?

12 A. The history from visits on 6/26 or
13 6/27/96 indicated that he had had a cough for a
14 week or so that was troublesome to him. And I did
15 note that he had had a cough and some difficulties
16 back in January of '96 and had seen one of my
17 partners then.

18 And but the first time of my interaction
19 during that calendar year was June 27th, with a one
20 or a week or so history of cough.

21 Q. Okay. At that time in June of '96 is
22 when you saw him. I don't see any reference to any
23 blood in his sputum or that he was coughing up
24 anything red or pink?

25 A. That's correct.

1 Q. All right. You were aware at that time
2 that there had been a report of that on prior
3 occasions?

4 A. Yes.

5 Q. And in January he had been seen by your
6 partner and had a problem with a cough, and at
7 least occasionally the cough was pink or bloody?

8 A. That's correct.

9 Q. Okay. And were you also aware that he
10 had been worked up in January and February of 1996
11 for purposes of determining if anything serious was
12 behind this cough or the blood and the cough?

13 A. Yes, I was aware of the visit that he had
14 in January, and I was always aware that he had had
15 I believe two x-rays during that time period, one
16 in January and one in February of '96 I believe.

17 Q. Okay. And were those chest x-rays a
18 standard and appropriate diagnostic method used by
19 your partner in that period of time for this issue?

20 A. I believe they were.

21 Q. Okay. And were they successful in ruling
22 out any sort of tumor on x-ray at that time and
23 were they?

24 A. I believe they were.

25 Q. I mentioned that there was a page that

1 needed to be added into this chart in order to have
2 it be complete, and that was the one. That is now
3 called Exhibit 918, which happens to be an addendum
4 to the x-ray reports from the January and February
5 time period.

6 Are you aware of an item referred to as
7 an addendum in the x-ray chart in your office
8 files, Doctor?

9 A. Yes.

10 Q. And just to give the jury the rest of
11 these time periods, there's an x-ray, chest x-ray
12 report, our Bate's number, Page 406 for a chest
13 x-ray that says it's January 22nd, 1996. Are you
14 familiar with that one?

15 A. Yes. There was an x-ray of January 22nd,
16 1996.

17 Q. All right. Now, we have looked at the
18 chart entries for when the contacts between the
19 patient and your partner took place, and it looks
20 like that might be a missed date?

21 A. Yeah. I believe that is the case, also.
22 I think the visit to the physician in the record
23 indicates that it was on January 23rd, and the --
24 at the very beginning of that x-ray report they
25 state that the date of the film was taken on 22nd.

1 So there is a discrepancy.

2 But in the written note of Dr. Spindel on
3 January 23rd, he did state that he took an x-ray on
4 that visit, and he viewed it himself. And so I
5 believe the x-ray was actually done on 1/23/96 and
6 is the basis of that.

7 Q. For purposes of anything that we are
8 going to talk about today, does it make any
9 difference whether it was the 22nd or the 23rd?

10 A. I don't believe so.

11 Q. Okay. There was a follow up x-ray done
12 because the physician thought it was important to
13 have a follow-up x-ray a month later?

14 A. That's correct, February 23rd another
15 x-ray was performed.

16 Q. Okay. And then the addendum that I
17 referred to is a report of a radiologist, not
18 taking additional films, but just comparing the
19 January and February films?

20 A. That's correct.

21 Q. And the conclusion of the radiologist at
22 that time was that there was no tumor visible on
23 these films and no serious change from one to the
24 next that was troublesome?

25 A. I believe that's correct. I think the

1 term used was that the appearance was now back to
2 the base line appearance of the 10/28/91. So, it
3 did go back and specifically compared the films
4 from 10/28/91, 1/22/96, and the February 23rd film.

5 Q. Okay. And we also have I think it's page
6 407 based on the x-ray report from 10/28/91, and I
7 didn't really leave room to put that in on here.
8 I'll put it above your name.

9 So, as of March, when the addendum was
10 written, the radiologist in your clinic had the
11 advantage of chest x-rays from 1991, actually, they
12 had chest x-rays from years before, as well, didn't
13 they?

14 A. Correct.

15 Q. Chest x-rays for '91, chest x-rays from
16 January '96, chest x-rays from February '96, and
17 the conclusion was they had adequately ruled out a
18 tumor at that time and no diagnosis of any disease
19 process like that took place as of that time?

20 MR. SIRRIDGE: Objection, Your Honor.

21 That is leading.

22 THE COURT: It is.

23 MR. GAYLORD: I'll rephrase the question.

24 BY MR. GAYLORD:

25 Q. What, if any, conclusion did your

1 clinic's radiologist draw about the comparison of
2 these various films as of March 1996, Doctor?

3 A. I think he felt there was no appreciable
4 change in the films from '91, 1991 to 1996.

5 Q. Okay. By the way, the 1991 films had
6 been made in conjunction with your first contact
7 with Jesse Williams that we mentioned earlier?

8 A. That's correct.

9 Q. And at that time he was having his
10 intermittent coughing and bronchitis-type symptoms
11 and some blood in his sputum?

12 MR. SIRRIDGE: Again, Your Honor,
13 leading.

14 THE COURT: Sustained.

15 BY MR. GAYLORD:

16 Q. What was the status of his coughing
17 condition when you saw him in October 1991, Doctor?

18 A. Again, referring to my initial visit with
19 the patient, he had had a cough for several months.
20 And I do note in the record that on occasion he
21 would bring up some blood with that sputum
22 production. And we did some laboratory testing and
23 that x-ray on that date, trying to evaluate his
24 illness at that time.

25 Q. Okay. And had you been able to satisfy

1 yourself in that 1991 time period that Jesse
2 Williams, although he had ongoing -- let me -- I'm
3 going to rephrase my question.

4 What, if any, conclusions did you draw
5 about whether Jesse Williams had a serious or
6 life-threatening lung disease in the 1991 time
7 period when you were involved with him, Doctor?

8 A. At that point, I felt that he had an
9 infectious reason for the cough and an element of
10 chronic bronchitis.

11 Q. And did you treat him with antibiotics at
12 that time?

13 A. At that time, my record does not indicate
14 a treatment with an antibiotic on that occasion.

15 Q. Okay. To your knowledge, did that
16 condition in that October 1991 time period resolve
17 satisfactorily?

18 A. To the best of my knowledge, I think
19 that's correct.

20 Q. Okay. Now then let's go back to your
21 contact with Jesse Williams in June of 1996.

22 You told us again that he had a cough
23 again as of that time. On that visit, did you make
24 any recording of any blood in his coughing?

25 A. I did not record any history of blood in

1 the sputum, that he was bringing up, in and around
2 that time.

3 Q. Okay. You haven't discussed yet one
4 other finding as of that date, and I'll ask you
5 about it.

6 Was there an observation brought to your
7 attention at that time about any changes in weight?

8 A. We had a weight recorded at that time,
9 which we usually do on each visit for each patient,
10 and I have to look at my record to see if I -- if I
11 note, made any particular mention.

12 Q. Maybe I can help you. On the fourth --
13 third and fourth line of your subjective part of
14 your report, do you say he has lost about ten
15 pounds in the last few weeks?

16 A. Okay. Yeah, I did make a mention of
17 weight loss, which he must have indicated had come
18 on relatively recently. The previous weight that
19 we had on him was in January 23rd, 1996. He
20 weighed 200 pounds at that time, and he weighed in
21 at 189 pounds on June 27th.

22 Q. Okay. Now, as of June of 1996, were you
23 aware that he had been worked up for possible
24 evidence of tumors in as recently as three, four or
25 five months before?

1 A. I was aware of that valuation and x-rays
2 in January and February.

3 Q. Did you take seriously his complaints and
4 pursue them with your diagnostic skills in the June
5 1996 time period and thereafter?

6 A. I took them seriously. I really put him
7 on an antibiotic at that time and did not feel that
8 I needed to re-x-ray him at that time, was my
9 conclusion.

10 Q. Because of the recent receipt of the
11 other x-rays?

12 A. Right, and the fact that the cough didn't
13 seem to be bothering him again for a relatively
14 short period of time in the history.

15 Q. Okay. And did you have a follow-up visit
16 with Jesse Williams about two weeks later?

17 A. I did have a follow-up on 7/15/96.

18 Q. I'm not sure how well the jury can see
19 this as I get down below the obstacles.

20 And how was he doing on July 15th, 1996?

21 By the way, that is our Bate's Page 289.

22 A. He reported to me at that time that his
23 cough was gone. He was still having the
24 difficulties with his appetite. And I did note
25 that his weight had declined further on that visit.

1 Q. Now, just skipping ahead for a moment to
2 ask you about a subject. We know that a few months
3 later in October of 1996 he was diagnosed with a
4 tumor.

5 I'm going to ask you in retrospect,
6 knowing what you know now and looking backwards,
7 can you tell us, tell the jury what was the first
8 sign or symptom that you now know was probably
9 related to his cancer?

10 A. I believe, again looking back, the
11 changes in appetite and the changes in weight are
12 significant factors that I associate with
13 development of cancer. And I think, again in
14 retrospect, I would put those things together and
15 think that things were beginning at that point in
16 time.

17 Q. Okay. And in your June 27th, 1996
18 subjective part of your dictated report you
19 indicated that he had lost ten pounds in the last
20 few weeks. So would that be -- does that
21 correspond what you can tell us today about the
22 earliest indication of a sign or symptom that you
23 now believe is related to his cancer?

24 A. I'm not sure I understand the question.

25 Q. I'm just trying to focus on the dating of

1 the first earliest signs of the weight loss. And
2 what we know is that your recorded that it was the
3 last few weeks as of June 207th; is that correct?

4 A. Right. I think, by his reporting, he
5 felt like he had lost weight in the last few weeks,
6 prior to that June 27th visit. By our charting,
7 you know, I concluded that he certainly had lost
8 some weight between January and June, and then he
9 subsequently lost more weight between June, the end
10 of June and mid-July of 1996.

11 Q. Okay. Now, in your July 1996 dictation
12 you indicated you had a plan for what to do next.
13 And the part of the last line of your plan I guess
14 is the part that indicates what you were going to
15 do with the question of possible malignancy?

16 A. On examination, I didn't see any
17 particularly disturbing signs other than the weight
18 loss, and I wanted to give it another month to see
19 how it played out. And he was having some other
20 difficulties that he wanted to evaluate. And I was
21 considering, I had in my notes, sending him to a
22 urologist for some other problems.

23 Q. Okay. There was a separate issue that we
24 are not going to dwell on. But, just so there's
25 not a mystery, he was experiencing some impotency?

1 A. That's correct.

2 Q. And you had some part of your plan was
3 dedicated to that issue?

4 A. That's correct.

5 Q. With respect to the question of any
6 malignancy involving his long-term smoking and his
7 chronic or recurrent coughing issues, what were the
8 last two sentences of your plan with respect to
9 that?

10 A. I said, my note reads, there's nothing to
11 suggest malignancy but the outside possibility of
12 that remains with the weight loss. We will simply
13 have to weight and see what happens over the next
14 month. I felt that, again, the respiratory
15 infectious part seemed to have cleared for the time
16 being.

17 Q. All right. And then is this a phone note
18 that is actually about six weeks later, than a
19 month later, regarding follow up from Mr. or
20 Mrs. Williams about his situation?

21 A. There was a phone or a phone call to our
22 office on 9/6/96 indicating that he had a cough,
23 upper respiratory symptoms again with some blood
24 production in the sputum. And at that point we
25 elected to treat him again with a course of

1 antibiotic on 9/6/96. We phoned that into the
2 pharmacy.

3 Q. All right. That is Page 290 of the
4 exhibits for the jury.

5 Then did you want to follow up from that
6 contact with the Williams? And did you get follow
7 up with the Williams?

8 A. We saw him approximately three weeks
9 later on the 26th of September.

10 Q. Okay. That is Plaintiff's Exhibit 164,
11 the first page of it.

12 And that date shows a full note of
13 another office visit, your standard dictation form.
14 And summarize for us what was the situation with
15 his symptomology at that point and what did you do
16 about it?

17 A. Well, I think he came in with his wife on
18 that visit. And the history revealed that he was
19 continuing to do poorly. It seemed like the cough
20 was back. There was still blood in the sputum. He
21 had continued to lose some weight. He was now down
22 to 177 pounds. He was also experience something
23 difficulties with breathing, getting short of
24 breath, sometimes noting wheezing at night from his
25 chest. And that was the significant part of the

1 history.

2 Q. Okay. With respect to the blood in the
3 and the phlegm, did you use the term sometimes
4 bloody phlegm?

5 I think it is the third line of your
6 subjective.

7 A. Right. Sometimes bloody phlegm.

8 Q. Okay. Did you note in that same
9 paragraph and in that same visit anything about the
10 state of his smoking, use of cigarettes?

11 A. I did make mention that he continued to
12 smoke and was unable to quit and that he smoked
13 about, by my history, at that point, about a pack a
14 day for many years.

15 Q. And are you familiar with references in
16 the chart sometimes suggesting one and a half or
17 two packs a day instead of one pack?

18 A. I have noticed that previously.

19 Q. By the way, were you aware during this
20 period of time that you were seeing Jesse Williams
21 as a patient that he had tried Nicorette gum back
22 in 1989 in the chart in an effort to quit smoking?

23 A. I can't say that I was aware of it at
24 that time. I do note that in looking back at the
25 chart at this point.

1 Q. Okay. There is a hand-written note from
2 September 1989, which is Page 318, Bate's number,
3 where do you know the signature from that note?
4 A. That was Dr. Lisk.
5 Q. One of your partners?
6 A. One of my partners at the same office.
7 Q. And it just says he was prescribed
8 Nicorette chewing gum?
9 A. That's correct.
10 Q. On the September 26th, 1996 date, again
11 did you order an x-ray on that date?
12 A. Yes, I did.
13 Q. And that is a chest x-ray?
14 A. That's correct.
15 Q. And is a diagnostic chest x-ray the
16 standard step taken under those circumstances in an
17 effort to identify or rule out a lung tumor?
18 A. I think that certainly is the first step.
19 Q. Now, you have radiologists at your clinic
20 and partners who specialize in reading x-ray films?
21 A. Yes, we have radiologists that interpret
22 all of the x-rays that we perform at our office.
23 Q. Okay. And were you then notified by one
24 of your radiologists, partners or members of
25 findings on the 9/26/96 x-rays that begin to tell

1 the tale of his diagnosis?

2 A. Yes. I was -- I obtained a report from
3 the radiologist that indicated there was some new
4 findings on the x-ray which were, in my mind,
5 needed further investigation and were suspicious
6 for lung tumor at that time.

7 Q. Okay. And was that the first indication
8 of a finding on an x-ray of lung tumor for
9 Mr. Williams?

10 A. I believe it was.

11 Q. For the jury, that is Page 403 of the
12 medical exhibit.

13 Did you have a conversation with -- I
14 can't read the -- oh, I'm sorry, it's typed here --
15 Dr. Aberman? Is that the radiologist?

16 A. I can't recall whether I had conversation
17 with him or whether I simply got the report from
18 him.

19 Q. Okay. Was there a recommendation from
20 the radiologist for what to do next in the way of
21 diagnostic study?

22 A. Yes. The recommendation was in his
23 report to do what they call a CT scan of the chest
24 area to get a more detailed picture of the inside
25 of the chest.

1 Q. And that is -- that was conveyed to you
2 either by the written report or by a conversation,
3 and we don't know for sure which?

4 A. Yes. I can't recall.

5 Q. Okay. On the copy we have been provided
6 of that chest x-ray report for September 26, 1996,
7 there's hand-written added in a space on the page
8 which looks like a check mark and the word "order"?

9 A. Right. Those are my notations. That
10 means that I was following through with that
11 advice. And the other check is my initials, which
12 I initial things or stamp them before they go into
13 the chart for filing, meaning that I have seen them
14 and reviewed them.

15 Q. And does your hand-written note tell us
16 whether or not a CT scan was ordered?

17 A. Yes.

18 Q. By the way, I want to ask you about
19 something before we go on to the conclusions of
20 that diagnostic work.

21 There is, in numerous of these pages of
22 the x-ray reports for these dates January,
23 February, March and September of '96 and earlier
24 dates, the October '91, even clear back in 1984,
25 there's a phrase that is used, and I just wanted to

1 ask you about it, about that phrase.

2 It says words, almost either these exact
3 words or some variations on them, it will say,
4 quote, "blunting of right costo phrenic angle,"
5 unquote. Do you know what I'm talking about?

6 A. Yes, I do.

7 Q. Okay. And I think that is reported on
8 January 23rd, February 23rd of '96, September 26th
9 of '96, October 16th of '96, and December of '84.
10 Maybe other times.

11 A. That's correct.

12 Q. Okay. Is that a finding that has any
13 meaning with respect to the diagnosis that we are
14 concerned about here today?

15 A. I don't think that that finding, having
16 trailed back so far into history and been still
17 being reported as a stable finding, I don't
18 consider that to be an important or key finding in
19 what had changed.

20 Q. Okay. Several of these reports of x-ray
21 refer to with that word "stable."

22 A. That's correct.

23 Q. Does that suggest something about whether
24 the radiologist compared the other films and
25 decided that it isn't a problem?

1 MR. SIRRIDGE: Objection. Leading.

2 THE COURT: Overruled.

3 Go ahead and answer, Doctor.

4 THE WITNESS: Yeah. I believe it does
5 reflect there, looking back on prior x-rays and
6 commenting on the similar nature of it.

7 BY MR. GAYLORD:

8 Q. Okay. Now I want to get back then to the
9 main point, and that is you had seen Jesse Williams
10 on September 26, '96. You had ordered the crest
11 x-ray. And then had communicated back to you the
12 advice that he should have a CT scan based on the
13 findings of a possible tumor on x-ray. A CT scan
14 was ordered?

15 A. That's correct.

16 Q. And what came of that?

17 A. I think the CT scan was performed on
18 September 30th, 1996. And there was an abnormal
19 mass in the central what they call the hilum of the
20 lung where the lymph nodes are, blood vessel are,
21 and some of the main bronchial tubes are all coming
22 together in that area. So, there was a mass
23 identified there on that region.

24 Q. And for our purposes, mass maybe is an
25 obvious enough word, but is that the lung tumor?

1 A. Yeah. A mass is it can be the tumor
2 itself. It can be lymph nodes in and around that
3 area. The lymphatics of the body are also in and
4 around that area. So it certainly reflects a
5 growth or a tumor or at least abnormal lymph nodes.

6 Q. With that information, did you believe
7 that you had a diagnosis in Jesse Williams' case?

8 A. Well, I think we had a very strong
9 suspicion of the diagnosis at that point of a
10 cancer, and but we needed to get a tissue diagnosis
11 from there to confirm that.

12 Q. Now, you have used words that sound like
13 they describe locations and so forth, but just to
14 be clear for our purposes, was it lung cancer?

15 A. Well, I think that was our leading
16 suspicion. I think the x-ray report reflects the
17 possibility of a condition called lymphoma at that
18 time, which is not a primarily lung cancer. So,
19 there still was a little diagnostic uncertainty yet
20 at that point.

21 Q. Okay. And did you take steps and issue
22 orders or requests to pursue the diagnosis further?

23 A. Yes. I feel like we needed to try to
24 establish a tissue diagnosis which involves getting
25 a biopsy of some tissue down in this abnormal

1 region, and I referred the patient to a pulmonary
2 doctor who was capable of doing a bronchoscopy, a
3 procedure that could look down into the airways and
4 areas and ascertain what abnormalities were there
5 and, hopefully, biopsy some tissue that would give
6 us a definitive diagnosis.

7 Q. And biopsy in this sense means through an
8 instrument that goes down the airways into the
9 chest to take a piece of tissue?

10 A. That's correct.

11 Q. And you referred Mr. Williams to what
12 doctor?

13 A. To Dr. William Turner.

14 Q. Okay. And Dr. Turner is a pulmonology
15 specialist?

16 A. That's correct.

17 Q. Who you frequently deal with on and his
18 group, at least, refer patients to for this kind of
19 purpose?

20 A. Yes.

21 Q. And did you receive back information that
22 provided a more refined and complete diagnosis?

23 A. Yes, we did.

24 Q. What diagnosis did you make, based on the
25 biopsy from the pulmonologist?

1 A. There was a tumor within the airway, and
2 it was biopsied and found to be a lung cancer.

3 Q. Now, on I'm looking at a page of your,
4 again, your dictated notes on October 11, 1996.

5 A. Okay.

6 Q. Do you have that?

7 A. Yes.

8 Q. And that is further follow up of all of
9 this process in a dictated report by you, but
10 there's handwriting on the bottom corner of that?

11 A. That's correct.

12 Q. Is that your handwriting?

13 A. Yes, it is.

14 Q. And does that indicate that you, by that
15 time, you received a preliminary pathology report
16 from the biopsy?

17 A. Yeah, I can't say whether I actually
18 received. The note doesn't say whether it was
19 through conversation with Dr. Turner, he had called
20 me with the results, or whether I had actually seen
21 a biopsy, you know, the official pathology report.
22 But I indicated that it was what I call the
23 squamous cancer of the lung. And that my other
24 notation there was I was going to keep him on
25 medication to try to continue to help reduce

1 swelling and improve his breathing, because he was
2 having trouble with the wheezing and the coughing a
3 lot at that point.

4 Q. Okay. Then did you eventually receive a
5 copy of a formal pathology report from that biopsy?

6 A. I believe I did. I'm searching for it
7 now. Yes, I did.

8 Q. Okay. For the jury's benefit, are you
9 looking at a surgical pathology report from Legacy
10 Laboratory Services?

11 A. Yes, I am.

12 Q. So, based on the letterhead, Mr. Williams
13 must have gone to Good Samaritan, the hospital
14 where Dr. Turner did the biopsy?

15 A. Let's see. I believe it was Emanuel
16 Hospital, which is part of the Legacy System.

17 Q. Okay. And for the jury, this is page 495
18 of the Bate's numbering. There's a number of
19 different notations on that page, but in terms of
20 the pathological diagnosis, would you identify and
21 tell me the pathologist's most refined statement of
22 what kind of tumor was identified?

23 A. They call this a poorly differentiated
24 carcinoma with adenosquamous differentiation.

25 Q. Okay. Poor Lee differentiated?

1 A. That's correct.

2 Q. Did I spell that right? Do I have those?
3 Are those the words that you just found in the
4 pathologist's report?

5 A. Well, they are not exactly. They are
6 poorly differentiated carcinoma with adenosquamous
7 differentiation.

8 Q. Okay.

9 A. So, it's a quite complicated term to
10 explain.

11 Q. Okay. Does poorly differentiated have
12 something to do with what the pathologist looks for
13 in terms of how aggressive or docile, so-to-speak,
14 a tumor is?

15 A. Recognizing I'm not a pathologist, but,
16 generally, the more -- when we talk about cancers,
17 typically the more poorly differentiated cancers
18 are more aggressive and more difficult.

19 Q. Okay. And adenosquamous. Is that a
20 pathologist's word indicating something about what
21 type of cells went wrong to form this tumor?

22 A. That is a fair statement.

23 Q. Okay. And carcinoma is a word meaning
24 cancer?

25 A. That's correct.

1 Q. Okay. Now, as the primary physician
2 diagnostician in this case, did you form any
3 conclusions about whether this was a type of cancer
4 that was known to be caused by smoking?

5 A. Yes, I did.

6 Q. Did you form an opinion to a reasonable
7 medical probability whether Jesse Williams' lung
8 cancer was caused by smoking cigarettes?

9 A. I believed it was.

10 Q. And now subsequently in March of 1997
11 Jesse Williams died. And you have, I see in your
12 hand, a copy of the death certificate?

13 A. I do.

14 Q. And in the interim time between October
15 of '96 and March of 1997, did you continue to have
16 an active role in his care?

17 A. I did not have an active role in his
18 care. I had referred him to, after this diagnosis,
19 to one of our medical oncologists or cancer
20 specialists for treatment.

21 Q. Who's that?

22 A. That is Dr. Gerald Segal.

23 Q. He's one of your partners and his
24 specialty is the treatment of cancer after they are
25 diagnosed?

1 A. Yes.

2 Q. All right.

3 By the way, had you ever discussed
4 smoking with Jesse Williams?

5 A. On occasion, we discussed smoking with
6 him, yes.

7 Q. I'm aware of a note, I think we talked
8 about it already, on the June 27, 1996 chart entry.
9 I have got the right one. You said he was a smoker
10 of one and a half packs a day. And then I think I
11 was mixing that up with the other one.

12 A. Might be -- well --

13 Q. I'm not seeing exactly which one. It was
14 one of your dictations, and I'll find it. It
15 indicates that he had difficulty quitting smoking.

16 A. There was a mention on June 27th, 1996
17 that I encouraged him to stop smoking. He would
18 seriously consider that. That is one that I see.

19 Q. Okay. My question about that is just
20 this. We have heard suggestions in the case here
21 about what physicians do with respect to patients
22 and smoking.

23 Did you always routinely, without fail,
24 discuss quitting smoking with Jesse Williams?

25 A. I don't say -- I can't say that every

1 visit I routinely discussed quitting smoking. I
2 think my usual style would be to periodically bring
3 that up visits. And I may or may not spend a lot
4 of time doing that at any particular visit. And it
5 may or may not be reflected in charting, depending
6 on how much emphasis was placed on that during the
7 visit to the physician.

8 Q. Generally speaking, if you pursued the
9 subject with a patient like Jesse Williams of
10 trying to get him to quit smoking or talked about
11 efforts to quit smoking, to put serious emphasis on
12 it on a given visit, would that be reflected on
13 your charting for that visit?

14 A. I believe that is a fair statement.

15 Q. Did you make any observations from the
16 sources available to you about the aggressiveness
17 of Jesse Williams' cancer?

18 A. Well, I felt that his big difficulties
19 began in 1996 with this, and that it was looked for
20 with some x-rays early in 1996 and it just couldn't
21 be ascertained at that point that it was there.
22 And it appeared in an aggressive way later in 1996.
23 So, I felt that really things came to light during
24 that time in a fairly quick way.

25 Q. Have you formed an opinion, to a

1 reasonable medical probability, whether the
2 cigarettes that Jesse Williams had smoked during
3 the preceding eight years before his diagnosis was
4 a substantial contributing cause of the cancer and
5 his death?

6 A. I believe they were.

7 MR. GAYLORD: Thank you, Dr. Kern.

8 THE COURT: Cross-examination.

9 MR. SIRRIDGE: Yes. Thank you, Your
10 Honor. I was going to take a couple a minute or
11 so to set up.

12 THE COURT: Sure.

13 MR. SIRRIDGE: Sorry we didn't figure
14 this out before.

15 THE COURT: Are you going to need the
16 witness down near the monitor?

17 MR. SIRRIDGE: It's possible, but he has
18 his own chart with him so that probably will not
19 be a problem.

20 May it please the Court.

21 THE COURT: Certainly. Go ahead.
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CROSS-EXAMINATION

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BY MR. SIRRIDGE:

Q. Good afternoon -- I guess good morning,
Dr. Kerns.

A. Good morning.

Q. My name is Pat Sirridge. I represent the
Defendant in this case Philip Morris. I understand
from your testimony, Dr. Kern, that you are a
general internist?

A. That's correct.

Q. And you're with the group, I guess,
didn't it begin as the Bodine-Cantrell Group?

A. That's correct.

Q. And become Metropolitan Clinic and then
become Health First?

A. That's correct.

Q. So, some kind of merger or joinders or
whatever they are doing these days?

A. That's correct.

Q. Okay. Am I correct that you did not see
Mr. Williams as a patient until 1991?

A. That's correct.

Q. Other doctors in your group had treated
him since, oh, the late '60s or so?

1 A. That's correct. The chart began in the
2 late '60s.
3 Q. Dr. Smith, Dr. Ritzenthaler, Dr. Shute;
4 those are all people in your group?
5 A. Yes, that's correct.
6 Q. So, when you started -- now how does it
7 work if someone makes an appointment with the group
8 and then come in with their doctor? Is that the
9 way it works?
10 A. Yes. They have the freedom to make
11 appointments with any of the doctors in the group
12 and follow with them if they care to.
13 Q. So, they could seek different doctors
14 from time to time depending on who's available when
15 they wanted to come in?
16 A. That's correct.
17 Q. We talked some about the record in 1991
18 where you saw Mr. Williams in June of 1991. Do you
19 remember that?
20 A. Let me see. I think it was in October of
21 '91.
22 Q. Oh. I guess 10/28/91?
23 A. That's correct.
24 Q. Right. It was June of '96. Right. And
25 this is Defendant's 889. And this is your dictated

1 note from the visit; right?

2 A. That's correct.

3 Q. I don't know if you can see it, but you
4 have got that one. This is 10/28/91, Defense
5 Exhibit 889.

6 Now, did you know that Mr. Williams had
7 told other members of your group at previous visits
8 that he had been exposed to dust chronically?

9 A. I don't believe I was aware of that.

10 Q. Let's see if your chart, Doctor, has
11 Defense Exhibit 893. 893.

12 Do you find that it is -- it would have
13 been from '88, a handwritten note?

14 A. What's the date in 19 --

15 Q. Well, good question. Mine is cut off
16 here. Something 7/88.

17 A. Oh. Yeah. Okay. 4/7/88. I see it.

18 Q. Look down in the last entry, Doctor,
19 where it says sort of starts with your Dr.
20 Ritzenthaler in there, but in that paragraph it
21 says: "Works at Portland School District, much
22 dust exposure chronically." Is that what it says?

23 A. Yes, I believe that's correct.

24 Q. And that would have been in the chart
25 there, in the clinic's, in Jesse Williams' chart;

1 right?

2 A. That's correct.

3 Q. Back on this 1991 record, Doctor, it
4 would have been your practice to go ahead and
5 review the clinical records when someone came in to
6 see you so you would have a feel for what their
7 history had been?

8 A. Yeah. I think we try to look back at
9 certainly some of the records over time.

10 Q. He had a history of bronchitis, according
11 to the records; right, Doctor?

12 A. Yeah. I think it's fair to say that he
13 was there on repeated occasions during certainly
14 the 1980s with repeated bronchial infections.

15 Q. And when doctors at your clinic see a
16 patient, say a smoker with a chronic persistent
17 cough that you noticed here, you would advise him
18 to stop smoking, wouldn't you?

19 A. I would.

20 Q. That would be almost standard care in
21 your group, don't you think?

22 A. I think that's correct.

23 Q. Now, do you advise to smokers to quit
24 because they can quit; isn't that correct?

25 A. I advise them to quit because I think

1 it's not good for their health.

2 Q. Well, that's true. But and it's harder
3 for some smokers to quit than others; is that
4 correct?

5 A. I think that's correct.

6 Q. But you have had situations where even
7 heavy smokers have quit; correct?

8 A. Correct.

9 Q. And were you aware, Doctor, that the
10 Centers of Disease Control in Atlanta have stated
11 that almost 50 million Americans have quit smoking?

12 A. I wouldn't dispute that figure.

13 Q. And also the figure that of those 50
14 million approximately 90 percent of them have quit
15 on their own? Do you dispute that either?

16 A. I don't have any reason to dispute it,
17 no.

18 Q. Well, that's a common way for people to
19 stop, to make a commitment to stop, and then quit
20 on their own; isn't it?

21 A. I believe that is a fair statement.

22 Q. And it's true other smokers seek out
23 smoking programs, isn't that true, stop smoking
24 programs in clinics and hospitals; isn't that true?

25 A. Patients will often do that.

1 Q. And there are programs run by
2 organizations like the Seventh Day Adventist, the
3 American Lung Association. I assume there are
4 hospitals that also run programs like this;
5 correct?

6 A. That's correct.

7 Q. And isn't it a fact, Doctor, that
8 Mr. Williams never asked you to refer him to one of
9 those programs?

10 A. Yes, I did not have any record that would
11 reflect his request of that nature.

12 Q. Now, Doctor, the records that we have
13 indicate that you did not see Mr. Williams as a
14 patient between 1993 and 1996; is that correct?

15 A. That's correct.

16 Q. And when you saw Mr. Williams again in
17 June of '96, you talked about that entry with
18 Mr. Gaylord; correct?

19 A. Yes.

20 Q. I know it's kind of hard flipping back
21 and forth between all of these entries, but I
22 believe you indicated, Doctor, in your testimony
23 that when Mr. Williams visited you in June of '96
24 that he had been treated earlier in that year?

25 A. That's correct.

1 Q. Now, Mr. Williams had been reporting a
2 hemoptysis, which is bloody sputum, on and off for
3 about seven months at the clinic, hadn't he?

4 A. In 1996 he had been reported to have it,
5 let's see, as far back as January of 1996.

6 Q. In effect, Doctor, in that January entry,
7 that 1/23/96 entry, can you find that hand-written
8 one?

9 A. Yes, I can.

10 Q. It says here productive cough times two
11 months; looks like mucous with blood, reddish?

12 A. Right.

13 Q. So wasn't that suggesting that he had had
14 the cough back in late '95?

15 A. I believe that is true.

16 Q. So, from late '95 to June, that is about
17 a seven-months period where Mr. Williams was
18 reporting a productive cough with hemoptysis on and
19 off to the clinic; isn't that true?

20 A. Correct.

21 Q. And I think you indicated, Doctor, in
22 your testimony that when you saw Mr. Williams in
23 June of '96 that he was not complaining or
24 reporting hemoptysis at that point? Do you
25 remember that?

1 A. Yeah, I didn't make any entry that
2 reflected -- well, let's see. There is an entry in
3 the visit that is in the hand-written form about
4 some red sputum that is noted.

5 Q. In fact, that was probably noted when he
6 came in reporting to the nurse and began taking
7 various initial measurements, that sort of thing;
8 right?

9 A. That's correct.

10 Q. Yeah. But that note of hemoptysis did
11 not make it into your note, in your dictated note,
12 did it?

13 A. It did not.

14 Q. So, it is now your recollection that
15 Mr. Williams was reporting some problems with
16 hemoptysis in June of '96?

17 A. Yeah. I have to -- I would have to say
18 that's correct now that I look back at that
19 hand-written entry there.

20 Q. And that was the entry where you
21 suggested, you encouraged Mr. Williams to stop
22 smoking, and he will seriously consider this;
23 right?

24 A. That's correct.

25 A JUROR: Your Honor, we cannot read

1 that. I mean, if it's important enough to put it
2 on the screen, it would be nice if they could get
3 it in focus.

4 THE COURT: Thank you.

5 MR. SIRRIDGE: Sorry about that.

6 BY MR. SIRRIDGE:

7 Q. Right down in the plan there, "Encouraged
8 him to stop smoking and he was seriously
9 considering this."

10 I don't know if you can see that or not.
11 Let me see if I can highlight it. "Encouraged him
12 to stop smoking, and he will seriously consider
13 this."

14 THE COURT: Your highlighter is not
15 highlighting.

16 MR. SIRRIDGE: Okay. I don't have a
17 secret highlighter here. I'm sure there's a
18 special one that works.

19 MR. DUMAS: Here.

20 MR. SIRRIDGE: Let's try blue.

21 (Whereupon, Mr. Gaylord flipped a switch on the
22 overhead projector.)

23 MR. DUMAS: Thank you, Mr. Gaylord.

24 MR. SIRRIDGE: Technology has never been
25 my thing. I'll say that.

1 BY MR. SIRRIDGE:

2 Q. So, just to make sure we didn't miss
3 anything, it was the day before or actually it is
4 the same day, just a hand-written note.

5 So, cough all week. Cough all week. Red
6 sputum. Shortness of breath. S.O.B; is that what
7 that means?

8 A. That's correct.

9 Q. So, this is really the same entry on
10 1/27/96; correct? The hand-written entry, the page
11 before that one is really the same day?

12 A. Yes, 6/27/96.

13 Q. Thank you.

14 So, as we were saying, when you saw Jesse
15 Williams in June of '96, he had had been reporting
16 hemoptysis since late '95 to other members of your
17 clinic during this time period between January and
18 June; isn't that correct?

19 A. Correct.

20 Q. Doctor, we were talking, we were talking
21 about the type of lung cancer here. There is a
22 classification of lung cancer with a WHO or the
23 World Health Organization has established for lung
24 cancer. Are you familiar with that?

25 A. Yes.

1 Q. Would adenosquamous be one of the types
2 of lung classification?

3 A. I believe that is true. They often --
4 well, they often refer to that as non-small cell
5 lung cancer. It's in the classification.

6 Q. It's a type of non-small cell lung
7 cancer; correct?

8 A. Correct.

9 Q. There are other types of non-small cell
10 lung cancer; correct?

11 A. That's correct.

12 Q. But, in fact, adenosquamous is a rare
13 type of non-small cell lung cancer; isn't it,
14 Doctor?

15 A. I'm not sure how rare it is from a
16 statistical standpoint. I couldn't comment.

17 Q. Are you familiar with literature which
18 says it happens about twice in 200 cases?

19 A. I'm not really familiar with that detail
20 of the literature.

21 Q. Doctor, would you agree that some cell
22 types of lung cancer are more associated with
23 smoking than other types?

24 A. Yes.

25 Q. And that squamous cell carcinoma,

1 small-cell carcinoma are highly related to smoking?
2 A. Yes.
3 Q. And adeno carcinoma and subtypes of
4 adenocarcinoma are less associated; isn't that
5 correct?
6 A. That's correct.
7 Q. And there are several subtypes of lung
8 cancer which are not associated with smoking; isn't
9 that true?
10 A. I believe that is true.
11 Q. Doctor, now you were kept informed of the
12 treatment and the diagnostic reports that were
13 going on with Mr. Williams in late 1996; weren't
14 you, after you referred him?
15 A. I can't recall. It's common for
16 Dr. Segal and I to, you know, for him to inform me
17 as to how somebody is doing. I can't specifically
18 recall how often or how much he kept me informed.
19 Q. Now, do you remember where the cancer was
20 located when it was diagnosed; the central portion
21 of the lung?
22 A. I think the -- I think Dr. Turner's
23 description is probably part of the record about
24 where it was located.
25 Q. Yes. How does adenosquamous carcinoma of

1 the lung typically present in the lung?

2 A. I think people will tend to have a cough,
3 and they may have extra sputum production, and they
4 may have blood mixed in with the sputum.

5 Q. Isn't adenocarcinoma or, excuse me,
6 adenosquamous carcinoma of the lung, isn't that
7 typically a peripheral tumor and not a central
8 tumor?

9 A. I may be getting out of my area of
10 expertise to give you a good answer to that.

11 Q. But if it were a peripheral tumor, you
12 wouldn't expect to have hemoptysis because that
13 occurs with central tumors; isn't that true,
14 obstructive tumors?

15 A. I think that is more than likely, but
16 again I'm getting kind of a way from my area of
17 expertise.

18 Q. Well, wouldn't it be fair to say that you
19 don't follow literature and wouldn't be able to say
20 whether Mr. Williams' cancer fit the typical
21 characteristics of adenosquamous carcinoma of the
22 lung?

23 A. Yeah. I wouldn't consider myself so
24 knowledgeable as to give you an opinion here.

25 Q. Dr. Kern, did you ever take an

1 occupational history from Mr. Williams?

2 A. I don't believe I did. I don't recall
3 taking one, and I don't think my notes reflect
4 that.

5 Q. Well, do you know that Mr. Williams
6 reported being exposed to dust and asbestos
7 chronically to his other treating doctors? We saw
8 that one entry from I believe it was '88?

9 A. Right.

10 Q. Do you know if he reported to other
11 doctors that he had been exposed to dust and
12 asbestos?

13 A. I believe I read over some information
14 from Dr. Segal that reflected that.

15 Q. And did you ever ask Mr. Williams about
16 his family history of cancer?

17 A. I can't recall that I did.

18 Q. Now, I was listening to your testimony,
19 Doctor, and I understand or think you gave opinions
20 about smoking causing Mr. Williams' cancer?

21 A. That's correct.

22 Q. Now, what were you relying on for your
23 opinion that smoking caused adenosquamous carcinoma
24 of the lung?

25 A. Well, I was looking back at the

1 difficulties that he had with the significant
2 amount of airway irritation he had over several
3 years in time, the fact that he had repeated
4 infections, the fact that he had repeated blood in
5 his sputum, I felt that was indicative of
6 irritation of the airway to a significant degree
7 that, in my mind, would carry enough to cause the
8 cancer to develop.

9 Q. In reaching your opinion, would you also
10 be relying on your general review and knowledge
11 about the statistics of smoking and lung cancer?

12 A. In a general way, yeah.

13 Q. Right. Don't those same statistics
14 indicate, Dr. Kern, that if you give up smoking
15 your risk of lung cancer decreases or declines over
16 the years?

17 A. I think that is a true statement.

18 Q. And that would be one of the reasons that
19 you would recommend to people that they give up
20 smoking; true?

21 A. That's correct.

22 THE COURT: Excuse me, Mr. Sirridge, can
23 you give me an idea of how long your cross may
24 continue?

25 MR. SIRRIDGE: I would say under ten

1 minutes.

2 THE COURT: Unfortunately, I have got to
3 recess in less time than that.

4 Mr. Gaylord, would you approach with
5 Mr. Sirridge, please?

6 THE COURT: Doctor, I apologize, having
7 to recess before you are finished. I know you
8 have got commitments elsewhere, but I understand
9 it's easier for you to come back at 1:30 than
10 another day or later; is that right?

11 THE WITNESS: Yes.

12 THE COURT: Reluctantly.

13 MR. SIRRIDGE: We will be finished by
14 2:00.

15 THE COURT: Ten minutes just became 30,
16 Mr. Sirridge.

17 MR. SIRRIDGE: By the time I finish and
18 by the time redirect --

19 THE COURT: I don't mean to unfairly
20 pressure you.

21 MR. SIRRIDGE: It's all right.

22 THE COURT: I had a note that the jurors
23 are inquiring of me how on schedule the trial is,
24 and I want to assure them that we have been
25 talking about that. We are working on reducing

1 the number of witnesses that were expected in
2 order that only new material come to you. And I
3 think I can give you a more reliable estimate of
4 about when the case will come to you for
5 deliberation. I can estimate that better by the
6 end of this week. We'll recall the estimate was
7 four to five weeks, and I'm doing my very best to
8 see to it that you have the case within that
9 timeframe. Of course, I can't tell you how long
10 it will take you to decide the case.

11 So we are going to recess for now. We'll
12 resume at 1:30. Please leave your notes on the
13 chair. Don't discuss the case. Watch your step
14 coming on out of the box.

15 Thank you, folks, for your attention this
16 morning.

17 Anything for the record, Mr. Gaylord?

18 MR. GAYLORD: No, Your Honor.

19 THE COURT: Mr. Sirridge?

20 MR. SIRRIDGE: No, Your Honor.

21 THE COURT: Okay.

22 Doctor, 1:30.

23 And if there is a file that has to be
24 reviewed, I assume it has been, but if there is,
25 let's take that up during the noon hour, too.

1 MR. GAYLORD: I think there's just the
2 medical chart.

3 THE COURT: Okay.

4 We're off the record.

5 * * *

6 (Whereupon, the a.m. proceedings adjourned.)

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1 STATE OF OREGON)
) SS.
2 County of Multnomah)

3
4 I, Jennifer Wiles, hereby certify that I
5 am an Official Court Reporter to the Circuit
6 Court of the State of Oregon for Multnomah
7 County; that I reported in Stenotype the
8 foregoing proceedings and subsequently
9 transcribed my said shorthand notes into the
10 typewritten transcript, pages 1 through 143, both
11 inclusive; that the said transcript constitutes a
12 full, true and accurate record of the
13 proceedings, as requested, to the best of my
14 knowledge, ability and belief.

15 Dated this 15th day of July, 1999 at
16 Portland, Oregon.

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20 _____
 Jennifer Wiles
 Official Court Reporter

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